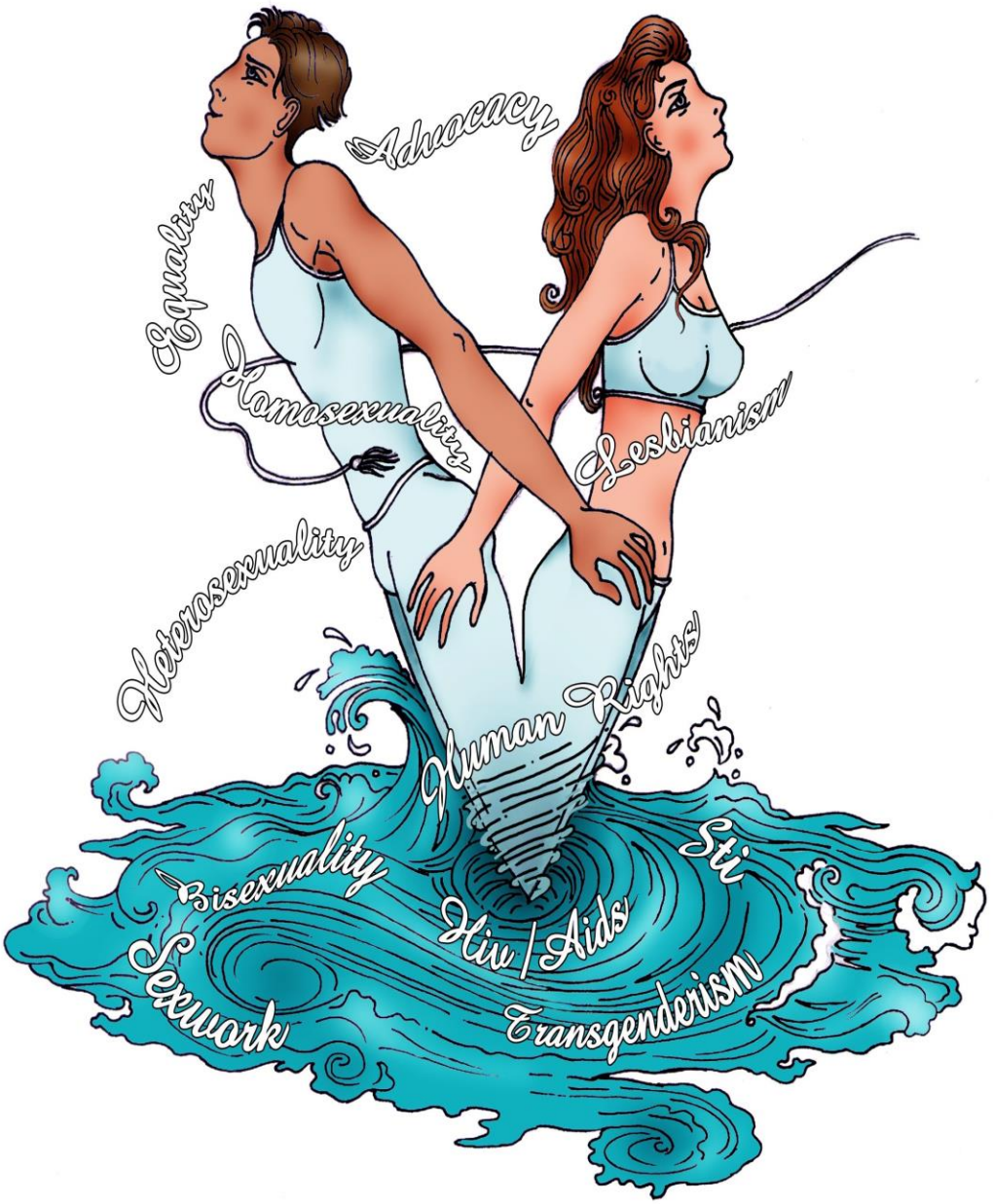
SAMABHAVANA
dignity in life

Sexuality Manthan



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DISCLAIMER

This manual is executed to facilitate Social researchers, Counselors, Doctors and Agencies for healthier functioning in the midst of Persons with Alternate Sexual Preferences and Behaviour in the sector of HIV and AIDS

It is our belief that the widespread availability of information about sexual matters can help facilitate better communication, and communication is the most important skill that one can bring to any relationship. The most important sexual organ is the brain.

Humans have a strong interest in sex, but it is relatively rare to encounter rational discussion about sex, even between partners. As with all activities about which people are passionate, and which involve biological drives, the topic of sexuality is rife with controversy, misunderstanding, stereotypes, and moralizing.

This manual contains information and explicit discussion regarding selected topics of alternative sexuality. If there is even the remote possibility that the contents of this manual might offend your sensibilities, we exhort you to go no further. If there is even the remote possibility that the contents of this manual might violate the laws or standards of your community, we insist you go no further. If you proceed you do so voluntarily, of your own free will. You, as an adult, must take responsibility for your own actions.

For further clarifications and if any queries please write to info@samabhavana.in

1) INTRODUCTION

'SAMABHAVANA' in Hindi means '*Equal Feelings*'. As suggestive by the name the organization is working to tackle issues encompassing lives of individuals with same sex preferences or alternate sexualities. The organization is non-funded and registered with the charity commissioner's office in Mumbai, India. The core team of the organization consists of like-minded people from different walks of lives joined with a determination to make changes. The organization has clarity in its vision and believes in the following.

- **Integration rather than differentiation**
  This actually means involving and sensitizing the society in issues effecting lives of sexual minorities and thereby making the social environment more conducive to live and co exist for people with alternate sexuality.
- **Creating safe environment**
  We intend to gradually develop a full-fledged center for persons with alternate sexuality that will deal with identity, counseling and advocacy.
- **Human rights and Advocacy**
  Archaic laws criminalizing same sex relationship exist in India that need to be repealed and a new set of partnership laws need to be ushered in giving legal recognition to same sex relationships. The organization will strive for bringing these changes by interacting proactively with the government and other legal departments along with cooperation of all other groups or individuals existing in India involved in similar activities**.**
- **Building International Bridges of Friendship**
  The organization believes in learning from the international experiences in this struggle for acceptance and rights of sexual minorities. Many western nations have made strides in liberating and recognizing rights of sexual minorities' rights. We will forge alliances with organizations existing in these nations and learn from their experiences and accept support for our activities.
- **Fighting 'The AIDS' menace**
  The organization is committed to the universal fight against the spread of AIDS. Our effort is towards encouraging safer sex practices, counseling to the affected and the infected, day care shelter for the infected along with nutrition and a vocational center for the affected and the infected. We intend to use all mediums including developing a India specific portal to spread awareness about HIV and AIDS.
- **Cultural Activities**
  From ancient times persons living with alternate sexuality had their own unique culture. In recent times this culture has gone underground and needs to be brought to the forefront. The organization will strive to hold arts and cultural events, which is the universal way for communication and bridging with the mainstream society.

We at Samabhavana believe that *"Sexuality is Reflection of Diversity"*

Love yourself, love all beings, and you will love God. The soul has no sex...body is immaterial, whether the attachment is for a male or female is immaterial; in spiritual sense, the sexual orientation does not matter. This is one of the very basic tenets of our Indian culture where we are taught to believe in the soul and not in the physical being. Being a part of such a progressive culture one really wonders about the roots of the current misconceptions about homosexuality in India. Our ancient scriptures always emphasized that it doesn't matter what

people do or whom they form relationships with as long as they do not harm others or themselves (ahimsa).

Samabhavana an organization working with persons of alternate sexuality and preferences has made this very mantra the focal point of their campaign. Centuries of Mogul and Victorian rule have not only made our country poorer in resources but also intellectually. We have forgotten that Co-existence and tolerance based on truth and ahimsa have been the corner stones of the Indian civilization. A country, which boasts of Kamasutra and erotic temples of Khajaraho, has somehow become myopic when it comes to discussing sex and sexuality. The existence of tritiya ling is a well-documented fact in our scriptures. Also our mythology is replete with examples of fluid sexuality of our Gods. Homosexuality has existed from as long as the human kind has existed and lets not forget that we all belong to the same thread of humanity just as Buddha said," we all derive from the same stem of life".

Samabhavana is making efforts to sensitize people with these facts and mainstream the gay movement. The point needs to be well made that homosexuality does not threaten the fabric of the society but only enriches it by creating transparency about relationships. It is important to understand that homosexuals exist in every field and someone maybe a son, a daughter, brother, sister, a good friend, your friendly neighborhood shopkeeper.

Sexuality is the essence of a healthy sex life, which in turn creates a healthy nation with individuals free from life long psychological trauma and depression due to non-acceptance of their sexuality. For any society the advantages of accepting same-sex relationships far outweighs the unfounded fears. Non acceptance of same-sex relationship would mean marriages between unwilling individuals due to family and societal pressure resulting in unhappy existence of the couple and their children and maybe broken marriages exerting unnecessary psychological pressure on kids from such unions. Lets not forget that children too have rights and no progressive society can ever be forgiven for ignoring them in the name of false morality and culture. Transparency about sexual habits of people also helps in containing spread of dreaded diseases like HIV and AIDS. It helps the department of health services to plan proper HIV intervention strategies thereby ensuring that safe sex is practiced and further infections are curtailed. Samabhavana feels that HIV intervention programs for the MSM (men having sex with men) need to be designed by taking into account the existing disempowerment in this community.

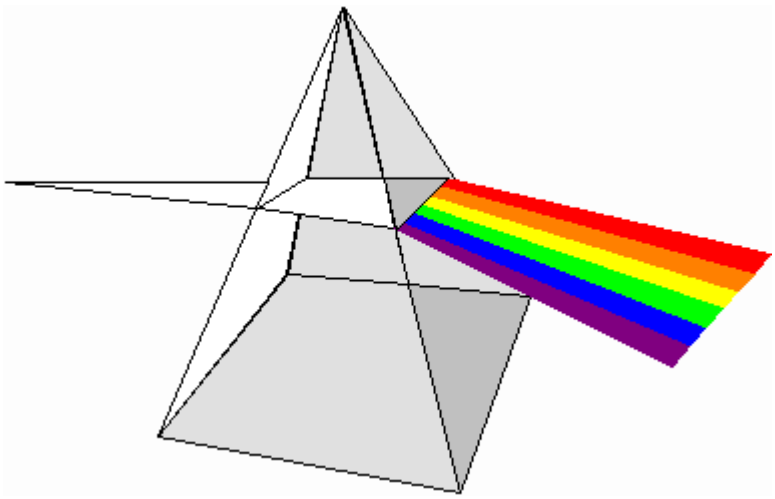
Samabhavana has been recently awarded HIV targeted intervention project by Maharashtra State AIDS Control Society (MSACS) where we are consciously making efforts to sensitize the general public, the health care providers, lawyers, the police about issues related to the gay community. An advocacy plan has been put in place wherein series of lectures on sexuality will be held in colleges, hospitals, the lawyers bar association focusing at the truth about homosexuality. This will in turn empower the gay community and also help them access government health facilities without fear of stigma and discrimination. It is a well-documented fact that in countries of the west where many have accepted homosexuals the HIV infection rate in this segment has really tapered and a large section of the gay community is practicing safe sex.

This decline is a result of social empowerment of the community, which has encouraged more and more persons to come to terms with their sexuality. Besides this Samabhavana has also completed a KABP study on male sex workers and masseurs. The popular misconception is that only women are a sought after

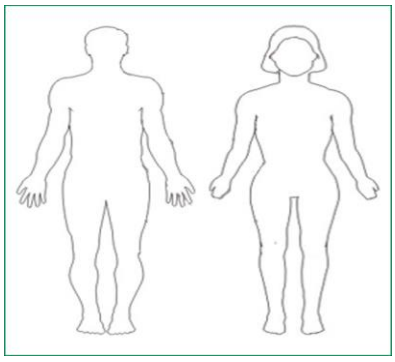
community and sex work only involves female prostitution but in reality there is a large community of young men ranging from economically backward migrant masseurs to hip college going youth indulging in prostitution. Again due to false notions of masculinity the society refuses to accept the existence of male prostitution. The clients of these male sex workers include both men and women. Samabhavana is in process of forming a collective of male sex workers and masseurs in the city of Mumbai, which will provide a platform for them to discuss issues surrounding their sex work. Samabhavana is currently encouraging these men to practice safe sex and is also helping them access health care. A lot needs to be done with this unseen community. HIV & aids has somehow managed to bring a lot of issues regarding people's sexual life on center stage. It only once again proves the age-old adage that one needs to tackle the root cause of any social problem and not the symptoms. Sexuality is such a burning social issue and the society can no longer confine it to the closet.

We understand that it is crucial to seek answer to the question that we ask for reasons of transparency and better perception hence It is imperative to first understand Human Sexuality, secondly what is sexual partner preference – per se heterosexuality / homosexuality and finally Men who sell sex and sex work/prostitution

Here we are trying and explaining a few realities why labeling should not be criteria for any research as *"Sexuality is Unbounded"*



2) Human Sexuality



Human sexuality has intricate meaning for both individuals and societies. It is a complex mixture of biological response, psychological meaning and societal/cultural overlays. The complexity of sexual behaviors in humans is produced by our high intelligence, and complex societies, rather than being governed almost entirely by instinct as in most other animals. However, instinct remains the main driver of human sexual behavior, even if its form and expression is dependent on culture and personal choice; this leads to a highly complex range of sexual behaviors.

It is only in recent years that sexuality has been studied in a scientific way by sociologists who seek to report and analyze current sexual behaviour.

Basically, sexuality refers to erotic stimulation. Erotic stimulation refers to what a particular society teaches are the pathways, directly or indirectly, to genital response. The learned aspect of erotic stimulation is obvious. For example we are told that a gynecological examination is not supposed to be erotic to either the client or the gynecologist and that husbands and partners therefore should not feel jealous concerning such examinations. If erotic arousal does occur in such a situation, a feeling of guilt or qualms will probably arise because there is no cultural support for such a reaction.

Another illustration of our learned eroticism is that many male-dominated cultures assert that for a male to reach orgasm quickly and easily, in a matter of seconds, is something to be proud of. On the other hand, western society today, contends that such a male is a premature ejaculator and needs therapy to learn to delay orgasm.

So each culture defines the proper way to behave and to think about erotic stimulation. There are cultures where female breasts are not part of the erotic imagery, and there are cultures where obese or very thin individuals are thought to be sexually attractive. Some cultures stress only heterosexual preferences, and others permit homosexual eroticism as well.

So, it is clear that the specific ways in which we think, feel, and behave concerning erotic stimulation are socially learned. It is true that without the ability to reach orgasm and without nerve endings to yield pleasure none of these sexual customs would exist. But it is also apparent that the specific way we become erotically stimulated is learned, because the biological factors are the same in virtually all societies but the customs still vary considerably.

Despite the tremendous diversity in sexual customs, in all societies there is an awareness of two major consequences of erotic beliefs and practices. These two consequences are *(1) physical pleasure and (2) psychological intimacy*.

Physical pleasure as a motivation for sexuality and as a consequence of sexual behaviour is often left unmentioned. The reason for this would seem to be that our culture has strived to restrict sexual behaviour and thus has tended to avoid mention of such pleasurable outcomes for fear of encouraging sexual behaviour. Our cultural traditions have tended to stress negative consequences such as unwanted pregnancy, venereal disease/HIV, guilt, and social condemnation much more than any positive consequences of sexuality. Despite these social attitudes, it is clear that the pleasure component of sexuality is the major reinforcement for the learning of sexual attitudes and behaviours. Of course, we do not refer to orgasm as the only sexual pleasure; we include all forms of subjectively felt pleasure related to a sexual activity. Defined in this way, pleasure is indeed a part of the vast majority of sexual acts and thoughts. However, non-pleasurable

responses may also occur. The sexual action may be uninvited and the response may be negative and painful. There may be guilt in addition to pleasure. In general however, pleasure tends to be the most common consequence of sexuality.

A second very common consequence of human sexual relationships is the development of *psychological* feelings of intimacy. Although sexual relationships without intimacy do occur - for example prostitution and casual sexual relationships.

3) Alternate Sexuality

Hetrosexuals, *Gays,* Lesbians, Bisexuals, Transgenders, Polyamorous and Asexuals have been around forever, right?

According to Bohan (1996), in early Melanesian cultures, homosexual activity between young males and adult males was an integral part of the youth's passage into manhood. This often included ingesting the older man's semen. Within this community, homosexual activity was essential rather than a threat to masculinity.

The continuum of sexual acts appears to have been omnipresent. Does this mean that ***sexual identity*** has existed indefinitely?

There are two camps. One is ***essentialism*** and the other is ***social constructionism***. The essentialist argues that one's sexual orientation is a core part of the individual's being; that homosexuality, heterosexuality, and bisexuality have always existed across history and cultures; and reflect an essential aspect of the human experience (Bohan, 1996). In contrast, the social contructivist sees that homosexuality, heterosexuality, and bisexuality as we comprehend them are products of specific historical and cultural understanding and are not universal and immutable aspects of human experience. The constructivist agrees that same-sex relations have occurred throughout history and among many cultures, but was not viewed as it is currently viewed. If culture did not define identity by the sex of one's partner, the constructivist contends that we would not define ourselves. Therefore, sexual identity is not an inherent part of the individual, but exists because of social definitions.

Culturally, the concept of homosexual identity began to take shape toward the end of the nineteenth century (Miller, 1995). A major contributing factor was the biomedical view of homosexuality. *It stigmatized it*, set it apart from the rest of society, and represented it as a medical condition or symptom of degeneracy.

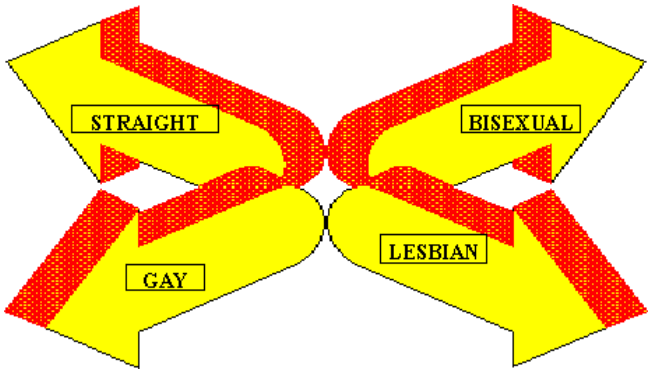
Another factor was economic growth. The emergence of industrial capitalism and the beginning of wage labor meant that homosexuals could remain outside of the heterosexual family and construct a personal life. The movement toward urbanization took people off of the farms and relocated them to big cities where individuals could find people like themselves. It was then possible to live outside of marriage and outside of the family structure. In the U.S. "identity politics" became fashionable in the post '60's period. The gay and lesbian community was viewed as just another constituency group or minority. With this occurrence more and more people felt confident and comfortable with "coming out".

The same holds true for us today in India, today we see great migration from villages to cities from there to mega cities for want of better economic independence, with the emergence of IT industry, boom in Bollywood the youth

that was at home and could not express himself gets a chance of doing so, by being staying single away from the shackles of family, where this person gets a chance to experience all that the city offers and with economic freedom, he is able to indulge in fulfilling all his feelings

The social constructivist stance is strengthened by the above cultural and economic changes. The change in the cultural climate can be seen if we compare the case of the Native American berdache to the present-day Native American homosexual (Williams, 1986). Today Native American homosexuals are treated with much disdain, no longer are they considered a gifted, respected part of the community. The reason here for the focus on homosexual identity is that sexual identity itself did not need to exist prior to the advent of the social construction of the homosexual. Furthermore, if there were not a stigma associated with sexual identity today, would there be a need for the definition?

3a) What is Sexual Identity?



Definitively, sexual identity is difficult to pin down. While some see sexual identity as gender, defining one as a male or female (Bohan, 1996), others see it as being identical to sexual orientation (the object of one's affectional feelings be it opposite sex or same sex), and still others see it made up of many components (Shively and DeCecco, 1993). Shively & DeCecco (1993) have one of the most comprehensive models. They believe that sexual identity is comprised of four components: *Biological sex, Gender identity, Social sex-role, and Sexual orientation.*

Biological sex is usually easy to ascertain. The doctor normally congratulates the parents on a bouncing baby boy or a beautiful baby girl. Of course, there are situations in which a visual determination is not always possible. At these times, chromosomal sex is determined. *Gender identity* is basically one's conviction of being male or female. This is not contingent upon biological sex. *Social sex-role* is primarily gender role. It refers to the socially ascribed to characteristics of what is masculine and what is feminine. Masculinity and femininity can be seen as one continuum or two separate continua (Bem, 1974). Lastly, *sexual orientation* historically has been viewed as a bipolar model ranging from heterosexual to bisexual to homosexual (Kinsey et al., 1953). Shively and DeCecco (1993) suggest the use of a model that has two aspects – one relating to physical preference and one relating to affectional preference. This model allows for both fantasy and behavior. One can have affectional preferences for the same sex, but does this alone make them homosexual? I am suggesting that it does not. The fantasy and behavior along with the other components define sexual identity.

Scientifically, the popularity of the dichotomous portrayal of sexual identity was introduced over fifty years ago (Kinsey et al., 1953). The Kinsey Heterosexual-Homosexual Scale (KHHS) was the first of the sexual response scales (Kinsey et al., 1953). In his study, 50% of the males were exclusively heterosexual, 4% were exclusively homosexual, and the remaining 46% fell somewhere in between.

The problem with the KHHS was that one was locked into a sexual category and variable aspects of sexual orientation (i.e., attraction, behavior, fantasy, lifestyle, emotional preference, social preference, self-identification) were ignored. Therefore, Klein (1980) developed the Klein Sexual Orientation Grid (KSOG) to extend the scope of the Kinsey model. Klein and his colleagues (Klein, Sepekoff, & Wolf, 1986) offer a multivariate model consisting of the following seven components: (1) S*exual behavior* – with whom do you have sex?; (2) *Emotional preference* – whom do you like or love?; (3) *Sexual fantasies* – whom do you fantasize about?; (4) *Sexual attraction* – to whom are you attracted?; (5) *Social preference* – whom do you socialize with?; (6) *Life style, Social world, and Community* – where do you tend to spend time and with whom?; and (7) *Self-identification* – how do you identify yourself? Each of these areas is rated similarly to Kinsey's along a seven point Likert scale from 1 (other sex only) to 7 (same sex only). Klein sees sexual orientation as an ever-changing aspect of self.

3b) Sexual orientation/preference/inclination/ Sexual Partner Preferences

Sexual orientation, sexual preference or sexual inclination describes the object of a person's erotic desires, fantasies and feelings, which is usually another person. Professionals and researchers generally use the term orientation in human sexuality, as opposed to earlier formulations such as "sexual preference." In general, human beings have one of three sexual orientations: attraction to individuals of the other gender is described as heterosexual; attraction to individuals of one's own gender is described as homosexual; attraction to either gender is described as bisexual. Along with biological sex (gender), gender identity (the psychological sense of being female or male) and social sex roles (cultural norms for masculine or feminine behavior), sexual orientation is one of the primary and enduring components of sexual identity. It should be noted that transgenderism--the sense that one's biological sex and gender identity are not congruent--is a separate matter from sexual orientation. It should be further noted that research in recent years has revealed sexuality as much more complex than most laypersons imagine. Even biological sex is not a simple, either-or, male-or-female phenomenon, but exists along a continuum.
Sexual behavior is not always congruent with sexual orientation. That is, persons who are primarily heterosexual may engage in sexual experimentation with someone of the same gender (for example, during adolescence), or may engage in repeated activity when no other outlet is available (e.g., in prison).). Similarly, homosexually oriented persons may engage in heterosexual acts, marry, become parents. In neither case does the behavior define the person's enduring emotion, affection and sexual attraction.

3c) Types of sexual Identities

Gay-Homosexuals- having sexual/emotional feelings towards other people of the same sex/ Sexual behaviour with people of the same sex/. Describing oneself as homosexual.

Bisexuals- Bisexuality is the potential to feel sexually attracted to and to engage in sensual or sexual relationships with people of either sex. A bisexual

person may not be equally attracted to both sexes, and the degree of attraction may vary over time.

Gay Married Man (GAMMA)- Throughout history, homosexual men have been wooing and marrying straight woman in order to provide a safe cover for their true sexual orientation, not all married homosexual men have come to terms with, nor have they even acknowledged, their sexual preferences at the time they married, They may try to deny their feelings, sharing in society's condemnation of homosexuality, going overboard in classic displays of "manly" behavior, showing that they are attractive to and can attract women.
Behavioral Bisexual Man (Prisoners, etc)-persons due to lack of opposite sexual companion and to under the influence of power at times show bisexual behaviour as in prisoners, etc

Transgender- is an umbrella term
Hijras/Ali`s or chakkas as we know them in India are the third gender maybe due to there way of lifestyle or the castration that they undergo to be known as Hijras or Transgender, that means the gender that has been interchanged. The hijra community is a group of interlocking matriarchal, ecumenical, and communal religious, social orders.
The hijra of India are a religious community who renounce male sexuality, identify with the creative power of the Mother Goddess and with Shiva. Although they may use male, female, or gender-neutral pronouns for any given individual, they insist that hijra as a group is referred to with feminine pronouns. The traditional occupation of a hijra is a performer. They may have sex with men or become prostitutes. The hijra have a penectomy and orchiectomy (removal of penis and testicles).
Transsexuals- Transsexual, both before and following surgery, may be heterosexual, bisexual, Lesbian, or celibate, with the proportion of celibacy being somewhat higher than with the general population of women.
Transsexuals are people who find their gender identity - the sense of themselves as male or female - in conflict with their anatomical sex. Some transsexuals may live part time in their self-defined gender. Many desire to live fully in their self-identified gender. Some undergo hormone therapy and sex reassignment surgery. People born in the body associated with one gender but believe internally that they are of another gender.
Male-to-Female (born in body of male, believe self to be female)
Female-to-Male (born in body of female, believe self to be male.

Transvestites also known as cross dressers - people who dress in the clothing, partially or completely, of the societal norm for the "opposite" gender. Most cross dressers are heterosexual men who cross-dress for pleasure. Bisexual and gay men who cross-dress usually do so for entertainment purposes, making fun of what it means to be a man.
DrAG Queens*-Dressed As a Girl
DrAB Kings*-Dressed As a Boy

INTERSEXUALS (historically called hermaphrodites)
A person born with mixed sexual physiology, with a physical manifestation of genital/genetic/endochronological differentiation which is different from the cultural norm. Intersexuals often are "assigned" a boy/girl gender, and surgery is done soon after birth to "correct" their "problem." The problem may well be our society's tightly held view that there are only 2 genders.

Polyamorous-is the nonpossessive, honest, responsible and ethical philosophy and practice of loving multiple people simultaneously. Polyamory emphasizes consciously choosing how many partners one wishes to be involved with rather than accepting social norms which dictate loving only one person at a time. Polyamory is an umbrella term that integrates traditional multipartner relationship terms with more evolved egalitarian terms. Polyamory embraces sexual equality and all sexual orientations towards an expanded circle of spousal intimacy and love. Polyamory is from the root words Poly meaning *many* and Amour meaning *love* hence *"many loves"* or Polyamory

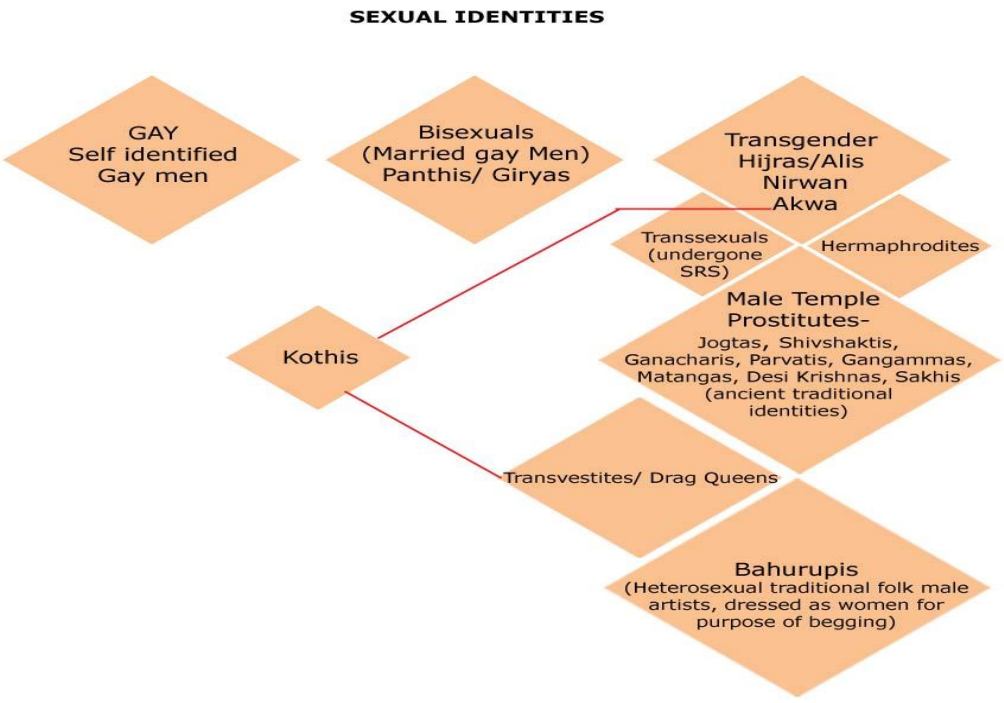
Lesbians- Lesbians are women loving women. They are women who are sexually attracted to other. Women who may feel emotionally and spiritually closer to women. Women who prefer women as their partners.

Transgendered women- women who think they are men trapped in women's body

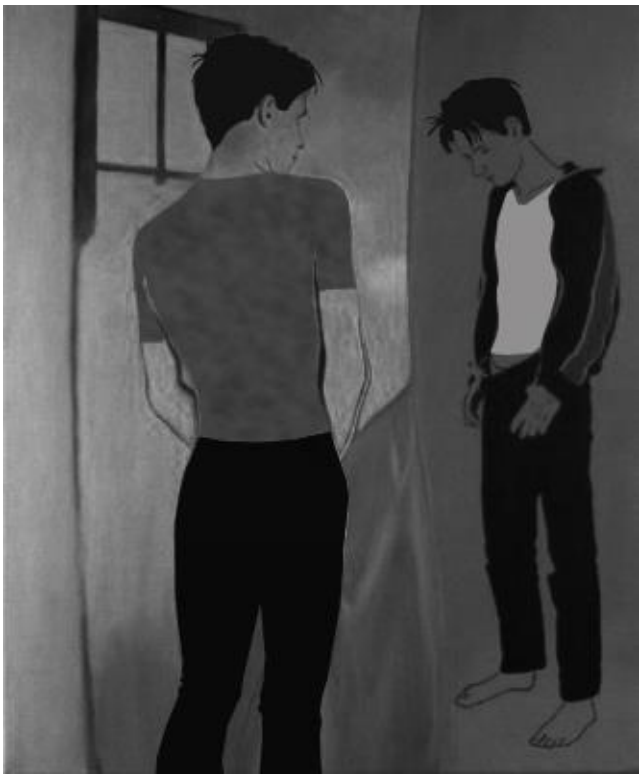
Asexual- A person who does not experience sexual attraction**.** Asexual people experience a minimal level of sexual attraction just as straight men experience negligible attraction to other men

Ancient Traditional Indian Sexuality Identities:
These are men who are dedicated to Lord Shiva or Goddess Parvati/shakti and its incarnations such as bhojraji mata/Murgawali or perceived to be possessed by Gods on specific days such as Tuesday or Friday and certain Auspicious days of Shivratri, Navratri –auspicious days in Hindu calendar - present day soothsayers

Shivshaktis, Parvatis, Ganacharis/Gandalus, Ardhanarshwaris, Gangammas, Jogtas/Joggappas, Desi Krishnas, Sakhis and Bahurupis



4) Homosexual Behavior:



Both homosexual and non-homosexuals may engage in overt homosexual behaviour but the significance of the behaviour is different in the two groups. Among homosexuals, behaviour is quite varied with neither partner necessarily being exclusively "active" or "passive". Emotional involvement and intimacy is present.

Homosexual behaviour in prisons and in the services generally, tends to be more stereotypic and designed for physical gratification. Certain men will be assigned submissive roles and rape commonly occurs.

Homosexual behaviour is a common experience. Although Kinsey et al. reported that only about 1 or 2 percent of the females and 4 or 5 percent of the males in his sample were "exclusively homosexual," he noted that 13 percent of the females and 37 percent of the males had engaged in at least one homosexual act to orgasm. Such acts often occurred in adolescence and did not develop into habitual patterns. There are no good trend data to indicate whether an increase or decrease has occurred in homosexuality in recent decades, and Kinsey reports no trends in his older data. In Maharashtra in India; Savara and Sridhar utilized a self-administered questionnaire that was published in a men's magazine in their study on **sexual behaviour**. A total of 1520 valid responses were received. About half of the respondents were unmarried. The first sexual experience had occurred with friends for 28.9%; with their spouse for 22.9%; with a paid partner for 21.8%; with relatives for 13.2%; with casual acquaintances for 10.4%; and with work acquaintances for 2.8%. 33.2% of the married respondents had their first sexual experience before the age of 20, while 31.1% had it between the age of 20 and 24 years .Of the 1158 respondents who ever had sexual intercourse, a significant number of respondents, 424 (36.6%) people, reported a sexual

relationship with a person of the same sex. The survey clearly shows the high incidence of homosexual behaviour.

The often-asked question by analyst is how good these figures are in Indian context where no definitive research has been done on sexuality/sexual behaviour. The answer is plain and simple that from the time we are born we are socially conditioned to a particular gender role. It is very difficult for any man to accept his homosexuality as it contradicts his masculinity. The entire basis of masculinity is based on the heterosexual matrix that hegemonic discursive/epistemic model of gender intelligibility that assumes that for bodies to cohere and make sense there must be a stable sex expressed through a stable gender (masculine expresses male, feminine expresses female) that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality. To blatantly label oneself homosexual itself calls for the realization, and ultimate rejection of the dominant gender sexual paradigms. It is a brave step indeed to then declare oneself a homosexual and alienating for ever the patricianly society. Hence it not easy to declare ones sexuality until such time that legislation is brought that everyone should be entitled to the same status and legal rights, whatever their sexuality. With no means to tackle the discrimination experienced by lesbian, gay and bisexual people in every sphere of life it is foolhardy to wear a badge of identity. People of alternate sexuality prefer to live their lives incognito through great psychological suffering in maintaining dual lives for the fear of alienation, stigma and discrimination. This leads them to having unstable multi-partner relationships and in most cases also compounds the situation with marriage and children. The emerging situation can easily be termed as high risk from the point of view of STI and HIV infections. Further for total apathy and lack of confidentiality by the staff providing sexual health services proper health seeking behavior is virtually non-existent amongst the homosexual community.

Many researchers want to leave it alone or leave it to the society. The subject is seen as too stigmatized; yet it seems that science has the ability to change that stigmatization. Think of the difference that removing homosexuality from the DSM made in the social acceptability of being gay or lesbian, not to mention no longer a psychological illness. Once science endorses all sexual identities, social customs can change, stigmatization can be made to become extinct, and maybe just maybe we can get to a place in society where once again *sexual identity* as a construct does not have to exist. But until the negative connotations are replaced with respect and regard, a complete society cannot be realized. Science has the ability to be the catalyst for change.

Science can be a change agent for altering homonegative attitudes, spurring social change, and increasing civil liberties for all of those who experience oppression because of their sexual identity. Until that day, gay, lesbian, and bisexual communities must rely on each other to forge ahead in social and legal equality, in reclamation of spirituality, and advancement of their distinct culture.

5) HUMAN RIGHTS & LAW

Though today in India, homosexuality is not penalized BUT its discriminated against in law presumably under section 377 of the Indian Penal Code- Unnatural offences

"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with (imprisonment for life) or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine.

Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section"

We are also going beyond that looking at other sections of law it is due to the fact that apart from Section 377 of the Indian Penal Code (and the Armed Forces Acts), no other laws directly deals (assumedly) with homosexuals. It is as if homosexuality does not exist in India at all. Because of this ostrich like attitude there is no overt discrimination against gay men and lesbians. The covert discrimination against homosexuals, however, runs throughout the gamut of laws.

This operates at two levels. First, the family law regime is based entirely on heterosexual premises. Under all systems of personal laws, marriages can only be between persons of opposite sex and succession and property rights are based either on blood relations or relations by marriage. Secondly, all laws (outside the confines of family laws) concerning entitlement to assets upon death of a person are also based exclusively upon heterosexual premises confined to relations by marriage and blood. Thirdly, because of the moral stigma attached to homosexuality per se, gay men and lesbians are affected by a number of laws which criminalise actions and other objects considered as immoral or scandalous according to the governing ethics of society.

Section 292 of the Indian Penal Code punishes obscenity and makes it a criminal offence. Definition of obscenity can lead to its misuse against gay and lesbian writings.

Section 292 (1) which defines obscenity states:
"(1) For the purposes of sub-S. (2) a book, pamphlet, paper, writing, drawing, painting, representation, figure or any other object, shall be deemed to be obscene if it is lascivious or appeals to the prurient interest or if its effect or, (where it comprises two or more distinct items) the effect of any one of it's items, is, if taken as a whole, such as to tend to deprave and corrupt persons who are likely, having regard to all relevant circumstances, to read, see or hear the matter contained or embodied in it."

As male homosexuality is a criminal offence the presumption is that it is something that is depraving or corrupting minds and bodies of persons and any writing or painting on gay issues can be banned by branding them as obscene. Thus, criminalising homosexuality has far reaching consequences much beyond mere prosecution under Section 377 and due to this section and information dissemination has hurdles.

The Dramatic Performances Act, 1876 empowers the State to ban any play that -- according to it -- is scandalous or is likely to deprave the spectators. A gay or lesbian play can easily be banned under this provision. Similar is the case with books and periodicals.

Under the **Indecent Representation of Women Act, 1986**, indecent representation of women is defined as depiction of the figure of a woman or her body that is likely to deprave or corrupt public morality or morals. Any book, photograph or picture which contains such indecent representation in any form can be banned.

Besides, under all **labour and service a law,** being convicted of an offence involving moral turpitude is treated as a major misconduct punishable with dismissal from service. Under certain laws it is not even necessary for a person to be convicted for moral turpitude but a mere opinion of the employer that an employee is guilty of moral turpitude is enough reason for the employee to lose his job. **Moral turpitude** is defined as anything that is shocking by the present moral standards of society; and in many cases adultery has already been held to be an offence involving moral turpitude. Employers can easily consider homosexuality to be an offence involving moral turpitude and this would be a constantly hanging sword over employees and would also prevent them from openly declaring or discussing their sexual orientation.

The **Juvenile Justice Act, 1980**, deals with neglected juveniles and juvenile delinquents. The State has the power to take away a 'neglected juvenile' from the care of parents and put the child in a childcare home. What is of crucial importance is the definition of neglected juvenile. The law defines a neglected juvenile one whose parent or parents are 'unfit' or associate with a person who leads an immoral or depraved life. This definition is potentially dangerous for gay and lesbian couples who may be bringing up one or the other's child. By using the argument of Sec.377 or even independent of it, it can be claimed that a gay or lesbian parent is unfit as he or she depraved and leading an immoral life.

We shall now have a look at some of the non criminal laws that affect gay men and lesbians.

Labour Laws1. Employees' Provident Fund Scheme, 1952

Under this Act and Scheme an employee is entitled to Provident Fund upon retirement/ resignation/ termination. The employee can nominate a person who will receive the Provident Fund in case of his/ her death.

Regulation 61 that deals with nomination reads:

"(3) If a member has a family at the time of making a nomination, the nomination shall be in favour of one or more persons belonging to his family. Any nomination made by such member in favour of a person not belonging to his family shall be invalid."

Regulation 2(g) defines family.

"Family means,

In the case of male member, his wife, his children, whether married or unmarried, his dependent parents and his deceased son's widow and children….

In the case of a female member, her husband, her children, whether married or unmarried, her dependent parents, her husband's dependent parents and her deceased son's widow and children

Thus, a gay or lesbian couple cannot nominate his or her companion for receiving the provident fund. Besides, under the Provident Fund Act, if no nomination is made the Provident Fund will go to heirs as per the personal laws. As a result, even here a gay or lesbian couple loses out

Payment Of Gratuity Act, 1972

The situation is similar under the Gratuity Act that deals with payment of gratuity to an employee at the time of his or her retirement/ termination/ death.

Nomination can be made by the employee and the nominee is to receive the gratuity if the employee dies.

Section 6 deals with nomination and reads:

"(3) If an employee has a family at the time of making a nomination, the nomination shall be in favour of one or more persons belonging to his family. Any nomination made by such employee in favour of a person not belonging to his family shall be invalid."

Here again, "family" is defined by blood and heterosexual marriage:

S. 2(h) defines `family'.

"`Family' in relation to an employee, shall be deemed to consist of-

- In the case of a male employee, himself, his wife, his children, whether married or unmarried, his dependent parents and the dependent parents of his wife and widow and the children of his predeceased son, if any, in case of a female employee, herself, her husband, her children whether married or unmarried, her dependent parents and the dependent parents of her husband and the widow and children of her predeceased son, if any

3. Workmen's Compensation Act, 1923

This Act provides that in case of death caused by injury at the work place, dependents of an employee are entitled to receive compensation from the employer. At a superficial level this appears to be a major departure from other laws, in that, the entitlement to compensation is based on dependency. However, the bias of the law is exposed in its definition of `dependents'.

" `Dependent' means any of the following relatives of a deceased workman, namely- a widow, a minor legitimate son, an unmarried daughter, or a widowed mother; and if wholly dependent on the earnings of the workman at the time of his death, a son or a daughter who has attained the age of 18 years and who is infirm

4. Employees' State Insurance Act, 1948

This Act deals with medical aid and benefits to employees.

Not just the employee but even his/ her family members are entitled to receive subsidised medical treatment from ESI doctors and hospitals. As in other labour laws, `family' is defined in a very restricted manner to include only relationships by blood or marriage.

Under this Act, if death is caused due to employment injury, the dependents of the employee are entitled to compensation. Here again, 'dependents' are defined in a very narrow manner to only include relations by blood or marriage.

Insurance Laws-Insurance Act, 1938

This is the Central law dealing with insurance policies including life insurance policies. While purchasing a policy the insured person is required to give the name of his/ her nominee. Under Section 39 of the Act the insured person can

nominate any person irrespective of whether he or she is a legal representative. This clause is a very pleasant departure from other laws dealing with nominees since it allows any one to be nominated for the policy amount. However, owing to judicial interpretation any potential use by gay men and lesbians of this law has been nullified. Various High Courts as well as the Supreme Court have repeatedly held that a nominee only acts as an agent for the legal heirs of the deceased person. Thus, the nominee is only meant for collecting the insurance money but the money actually belongs to the heirs and has to be paid over to the heirs.

Public Liability Insurance Act, 1991
This Act provides for compensation for the public at large (non workers) regarding accidents arising out of handling hazardous products. However, in the case of death of a person only his/ her legal representatives are entitled to claim the insurance amount.

Housing Laws -
Bombay Rent Act, 1947 on the death of a tenant, the tenancy passes to the tenant's heirs**.** A gay or lesbian tenant cannot even will away the tenancy to his or her companion.

One of our aims is to defend the rights of gays and lesbians and to reform these discriminatory laws, and to get others passed that expressly protect the freedom of sexual orientation and identity

This law needs to be carefully interpreted and seen that any act that does not procreate (against the order of nature) is illegal be it between heterosexual couple or that of masturbation an act that is enjoyed many youth

However, we are aware that legislative reforms alone will not put an end to the situations of discrimination and violence that many homosexuals suffer, because they are caused by a generalized homophobia that operates not only through legal channels, but permeates all spheres of society.

5a) HOMOPHOBIA

Homophobia is a term used to describe hatred and rejection of gays, lesbians and homosexuality. It refers to the fear or refusal of people, organizations, governments and other social actors to confront the reality and specificity of this non-heterosexual sexual orientation.

Homophobia has a direct, and often devastating, effect on the lives of homosexuals, who may suffer discrimination and abuse in their families, at work, health set ups or in other social spheres. The most extreme form of homophobia is expressed in what are known as 'hate crimes', in which verbal and physical violence, death threats, rape or murder are committed solely on the basis of the victim's sexual orientation.

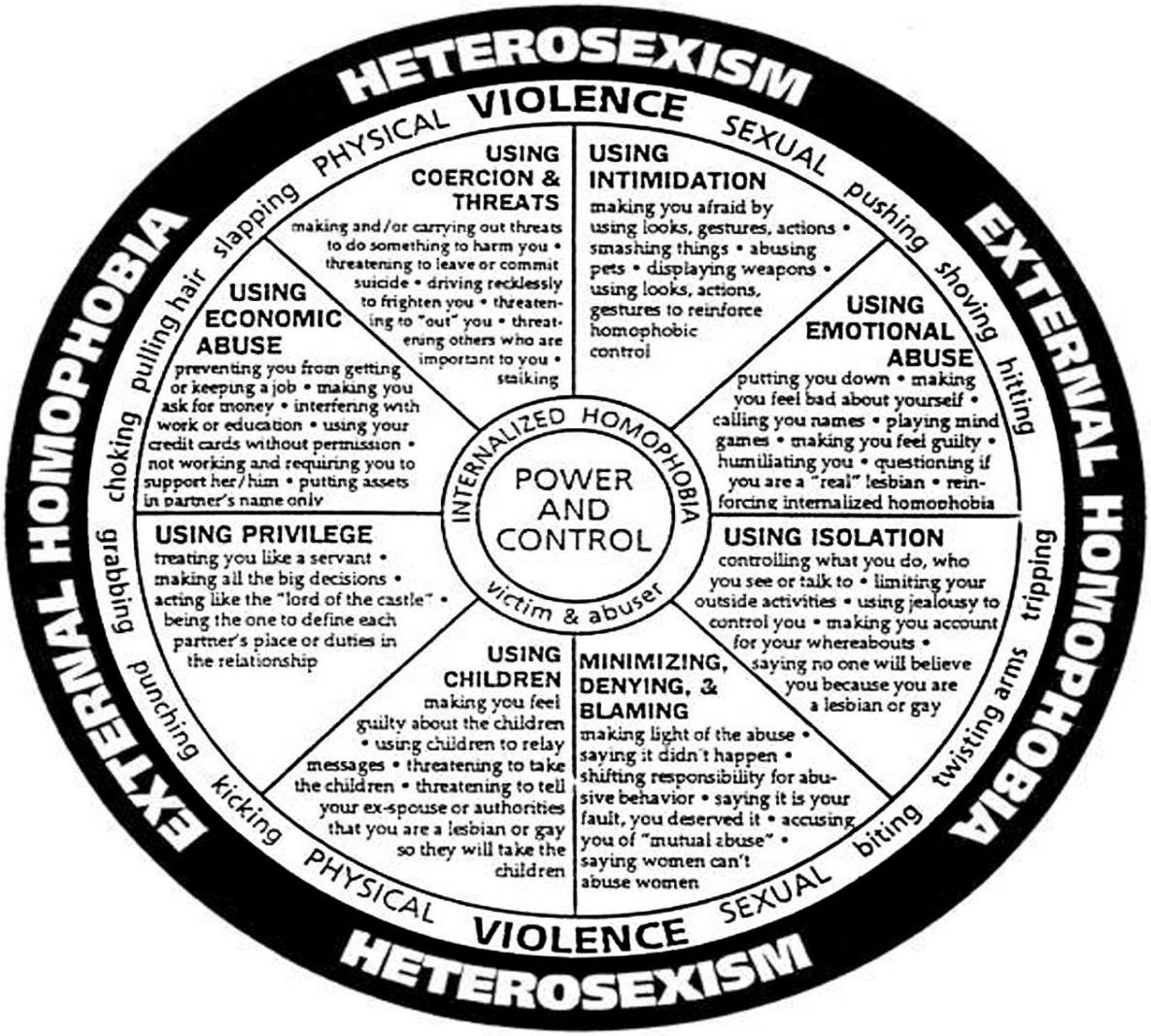
These expressions of inter-personal homophobia are often legitimized by the existence of institutional homophobia, which can take different forms: the non-implementation of strategies to educate and raise awareness on issues around sexual diversity; the refusal by state officials to guarantee lesbian and gay victims their right to equality before the law; or direct persecution by state agents, in particular the police, which may include blackmail, torture and extra-judicial executions.

Homosexuals who suffer extreme forms of persecution, either directly at the hands of the state, or at the hands of individuals or groups, against whom the state refuses to protect them, may be forced to seek asylum in other countries. However, only a select number of countries have national norms recognizing persecution on the basis of sexual orientation as grounds for granting asylum, and no international treaties deal explicitly with this issue.

Gay rights organizations engage in different activities designed to combat homophobia, reverse the impunity enjoyed by both state and private perpetrators of hate crimes, and put an end to persistent discriminatory practices that affect all aspects of homosexuals' lives. These activities include registering, documenting, publicizing and providing legal support for cases of discrimination and violations of the human rights of sexual minorities, and pressing for the recognition of those rights in international human rights circles; which Samabhavana has been actively doing by liaisoning with Human Rights Watch in New York, U.S.A. and other Ngo/CBO`s In India

Attached is a diagram that explains abuse and which also hampers a lot of intervention work

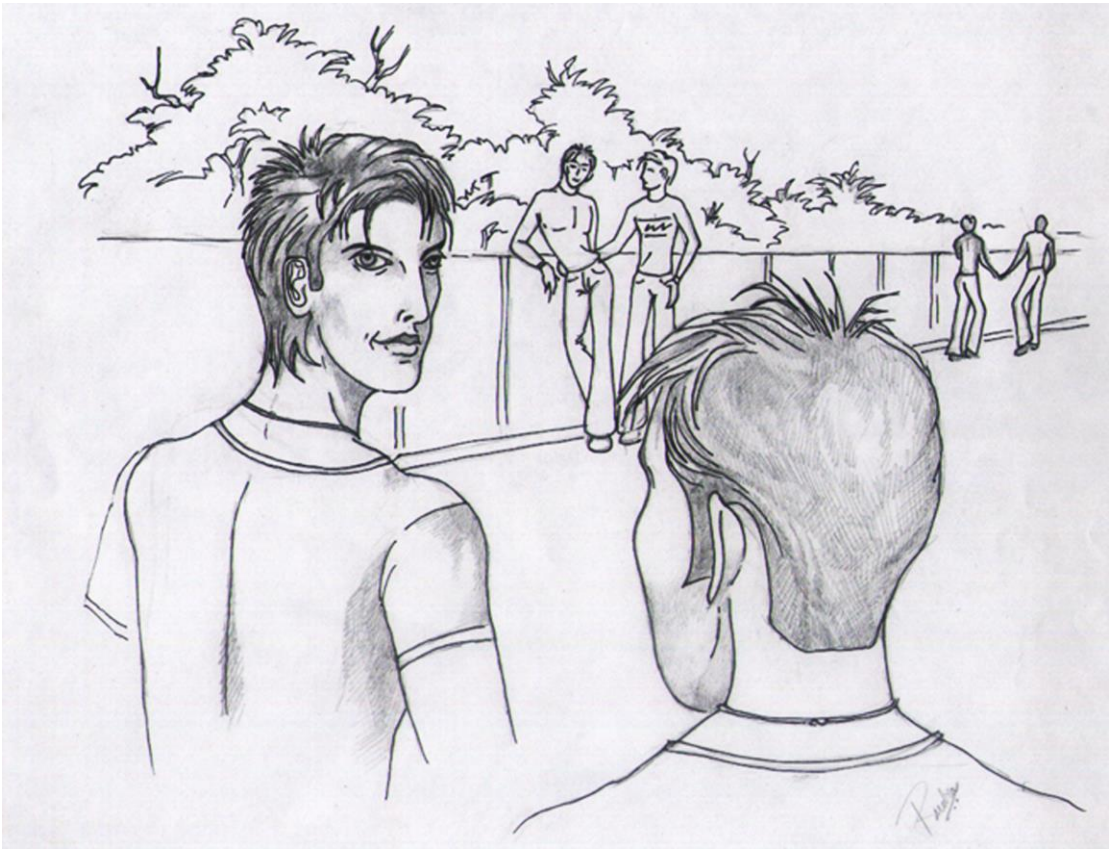
POWER AND CONTROL WHEEL FOR GAYS AND LESBIANS



6) Men who sell sex-

Definition: Male sex-workers are defined here as those males who engage in sexual activity with other males or females for the primary purpose of immediate financial and or material gain and the person completes the transaction and such a transaction is his source of income.

A sex worker provides a client with the use of his or her body in return for material gains. Working as a prostitute rarely contributes to that individual's sexual gratification. There is a distinct separation between "work" and the partner at home.



We know mostly about women who work in the sex industry because they are more common, but male prostitution (both homosexual, bisexual and heterosexual) is either becoming more common or certainly is being discussed more.

In case of Male Sex workers, as per cultural context man is supposed to enjoy sexual pleasure and woman (woman in prostitution and wives) to provide for them. Man cannot fail in proving his masculinity, which means his ability to penetrate, hold erection and ejaculate, whenever there is a woman at his service These norms are challenging to a Male Sex Workers and he has a conflicting gender identity for example Male Sex Workers taking orders from female clients

The role of prostitution in the spread of STI`s has varied through the ages, and varies from one country to another. Today its importance depends largely on the extent to which it provides the casual outlet and on the extent to which sex workers are infected. Sex work is the major casual outlet in countries, and the sex workers are heavily infected.

Those who do seek treatment may hide their involvement in the industry. Because of the double stigmatization of prostitution & homosexuality, Men who sell sex casually often do not identify themselves as sex workers. Over-policing can lead to a large subculture of people in this category.

Advocates for the maintenance of laws punishing sex work that this may deter people from becoming involved in prostitution and spreading STI`s. There is no evidence to support this. Similarly, compulsory testing for STI`s, including HIV, constitutes a personal rights issue, as well as the potential cause of many other problems. It can result in a false sense of security for both sex workers and clients; the "window period" for HIV can mask infection, and tests are accurate only until the next risky exposure. In short:

The treatment of Sex worker(s) . . . as willful children, who cannot be expected to look after their own health, is less effective than providing them with accurate health education and ensuring that they have the power to use it.

6 a) Sexual Orientation of a Male Sex Worker & Masseur:

In recent times in India a new debate has sparked of on sexual orientation of male sex workers (MSW). It is generally thought that male sex workers are homosexuals as most of their clients are supposed to be gay men. But the fact is contrary to this. Most of them are migrants and have come to cities in search of livelihood. As the case with their female sex worker counterparts they are also poorly empowered to make choices with their customers. Their job is to please their customers regardless of the sex of the customer. It is also true that they have female clients as it is very clearly seen in bazaar boys, parlor boys, gym boys, college students, film extras and upcoming models. The bottom line is very clear that monetary or other material considerations are the main criteria.
The fact also remains that homosexual sex workers also exist who mainly cater to gay men as well as national and international gay travelers as escorts. It is easy to spot such activity, as gay men are more explicit about their sexual needs. Here again there is a breed of sex workers who would not mind to escort male or female traveler clients, as monetary benefit is lucrative.

Indian gay identity is in the process of evolving in an Indian setting. Although you can meet Indian gay men who clearly share an identity influenced by the Western gay community, or may have even adopted it, MSW/Masseur have grown up in an environment in which *gay*, means (*Gandu/Chakka/Napunsak/Homo- a derogatory slang's – means one who gets penetrated or one who is impotent*)

(Many Indian gay men report fearing that they would become *Homo*. And we suspect that Indian gay identity, to a certain degree, has evolved in opposition to Homo.) So, naturally, the MSW/Masseur gave a good-natured denial. We do mean "good-natured," because being the passive partner or *Homo* are not negatively emotionally charged, as in the West; Here we should mention that being the receptive partner does not mean a Indian male sex worker "loses" his masculinity, unlike a (heterosexual) Indian man who may see it as losing his "honor" (Ijaat)), since the act is seen as part of his job. Nonetheless, gay men, as well as MSW/Masseur, can feel anxiety about and/or have a preference against anal receptivity. Only sophisticated and well-experienced MSW/Masseur are smart enough to answer that they are "gay" even if they prefer sex and a relationship with women. Most are aware that foreign gay men may have a strong preference only for other gay men. From the above it is very clear that masculinity is also a issue for these male sex workers. The very thought of them having to indulge in sex with another man or having to accept money from their female clients challenges the traditional norm of masculinity that is defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women. To reaffirm their masculinity they tend to have girl friends and periodically visit red-light areas for

their sexual gratification. This compound furthers their sexual habits and increases the risk of spreading infections to a large section of the society.

Here again there exists another breed of sex workers who are transgender (Hijra) and kothi sex workers. Kothi`s are effeminate homosexual men from India who dress up as women, 'marry' Panthis and perform the role of a wife. Panthis are men who have sex with kothi`s, dress and act like 'real men' and perform the role of husbands to their kothi`s. As already explained transgenderism means that one's biological sex and gender identity are not congruent and similarly kothi`s those who look, behave, think female confirm that they have an exclusive cliental of straight (heterosexual men) panthi`s who pay to have sex with them.

These are penetrative men and kothis are receptive in their role-play in bed. It is also clear that this type of sex work generally happens due to low accessibility of female sex workers or higher cost of female prostitutes and given a choice these straight men (panthi`s) would prefer a woman over the kothi/transgenders.

Anal sex is often considered rougher and dirtier than vaginal sex, and heterosexual Indian guys (panthi`s) who are seized with a desire to experiment would be inclined to seek a willing or effeminate, easy-to-subjugate guy to penetrate than attempt it on Indian women of stereotypically conservative sexual mores. Many heterosexually identified Indian guys would be happy to have sex with a feminine person (the more feminine the better), regardless of whether the feminine person is a biological female or an effeminate male, and regardless of whether the feminine person identifies as gay, straight or bisexual. A number of the panthi`s may have such desires. Because such men are attracted primarily to women, it might be easy for them to be attracted to kothi`s. The panthi`s may be the penetrative partners chiefly because their sex with other men is rooted in power. Also because such panthi`s may be bisexual or even heterosexual in their desires, their kothis might have to make extra efforts to keep their panthi`s and prevent them from breaking off and Indian societal notions of masculinity and machismo do not frown upon sex with another man. Instead, a man is free to sleep with whomever he wants as long as he marries a woman and raises a family. He is a 'na-mard' or non-man if he is unable to produce kids

It is also seen that kothis and transgender sex workers compete with female prostitutes for sex work in a particular operating area. It is evident that most of kothi and transgender sex workers indulge in giving oral sex to their clients that which is normally refused by a female sex worker or charge the client heavily for this activity. It is also important to note that most kothis /transgender sex workers seem to indulge in sex work out of their own need for sexual gratification.

As American sexologist Alfred Kinsey dramatically showed the world in 1948, human sexuality cannot be put into neat categories. His 0-6 point scale combined both behavior and fantasy to place his samples along a continuum, with 0 indicating exclusive homosexual orientation and 6 meaning an exclusive heterosexual one. Not surprisingly, the majority are neither 0 nor 6. And over time, people moved along that scale as well. So, as clumsy as the Kinsey scale is, it is certainly better than labels that are so dearly loved in the West.

We have for easy reference given an arrow drawing:

As shown below -

*Diagram **1** of their partners they access or they are accessed by*

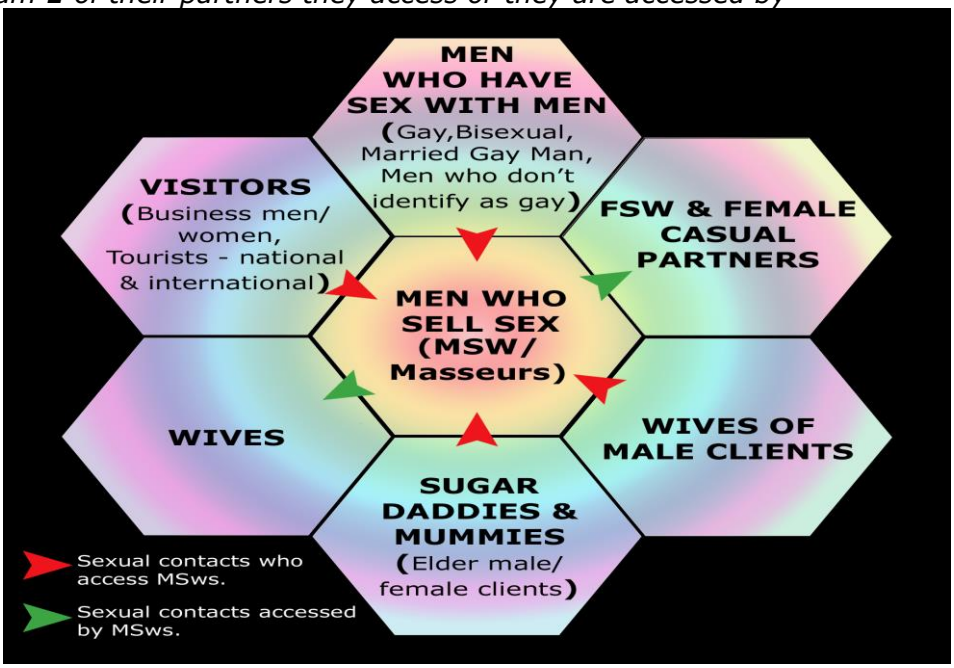
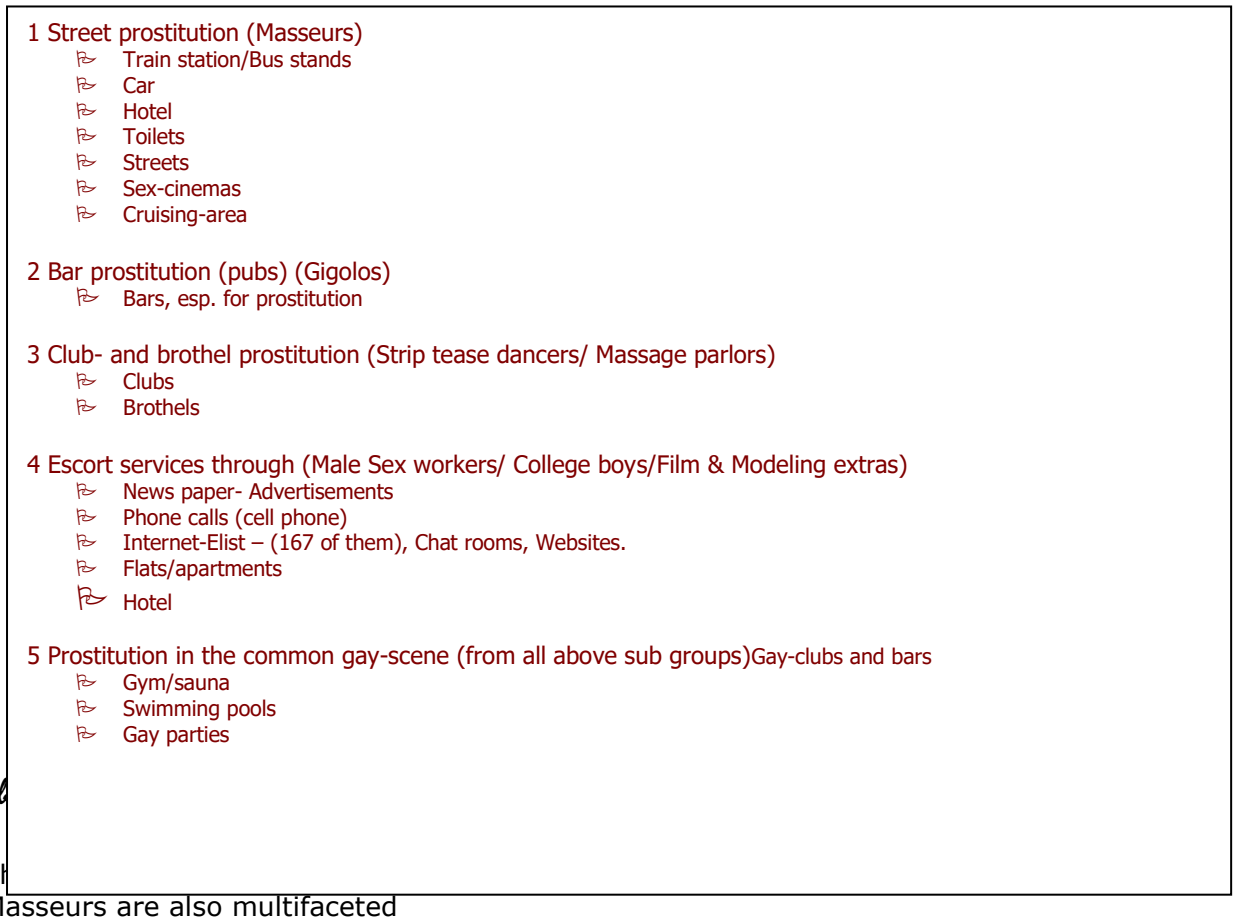


*Diagram **2** shows type of sex Workers*

Diagram **3** shows their work background

Diagram 4-Access points of Male Sex Workers/Masseurs



Masseurs are also multifaceted

- ☑ Migration
- ☑ Debt
- ☑ Bondage
- ☑ Marriage of female siblings
- ☑ Homelessness
- ☑ Lack of money
- ☑ Double stigma- Homosexuality & Prostitution
- ☑ Masculinity
- ☑ Substance Abuse- Alcohol, Cigarettes, Gutka/Mava/Tobacco, Hashish (gard), XTC, Uppers (designer drugs)
- ☑ Illegality
- ☑ Other conflicts with law –Bribe
- ☑ STI & HIV & AIDS
- ☑ Other illness- Acidity, Piles & Fissures, Backache, Sexual and Body hygiene
- ☑ Psychological problems- Self sexual objectification
- ☑ Relationship problems – Trust, love,

6c) STI & HIV / AIDS

Regarding HIV and STI prevention, we must be aware of the fact that this might not be the first priority for our target group. This applies especially for those who live in bad conditions, whose main priority is survival.

Prevention of STDs and HIV and health promotion in general is not easy. Simple prevention strategies that might be successful with average young people do not work here because they fail to take into account the complicated psychological and social backgrounds of the MSW. Some of them live following a day-to-day survival strategy. Their first need is often very basic and practical: money, drugs and a bed. This might partly explain why they are not very open towards information concerning their health. And it explains why for some of the MSW, taking care of their health is not a priority. Psychological factors are subtler but just as important. MSW might have been the victim of abuse (sexual or in another way) in their work environment. They often have a very low self-esteem. They do not really believe in themselves and do not see many prospects for the future.

They feel powerless in human relations, unable to stand up for themselves. This often makes negotiation about safe sex with clients difficult. HIV is a difficult topic to discuss because in the end they are very afraid of suffering, to die young, to die alone. Raising the issue is sometimes so confrontational that it is hard to talk about it. The subject often creates resistance that is hard to penetrate.

For two reasons we think it is important to link both services (health and social). First of all, social and psychological problems are often the cause of, or at themselves as a MSW.

But promoting and stimulating individual skills is least contributed to risk behaviour (like unsafe sex) and poor attention for one's health. Secondly, health is often not the most urgent priority of MSW.

Problems relating to legal status, housing and debts often come first. It is also very difficult to start a treatment or take care of your health if all these problems are crowding your life.

Samabhavana`s HIV/STI prevention sessions are focused on influencing unsafe sex behaviour by distributing 'hard' information on the one hand (different STI`s, ways of transmission, treatment…) and training negotiation skills on the other hand.

The distribution of hard information is important, as we have to deal with lots of false assumptions about ways of transmission and possible treatments, which are mainly based on anecdotes, myths and homophobic ideas. The second part of the HIV and STI training is focused on the specific interaction between MSW and customer /sexual partner.

Different questions need to be highlighted, e.g. why and in which situation is it hard to use a condom or how can we stimulate our customer/sexual partner to use a condom? This part in particular is strongly interactive and based on the individual experience of the participating MSW`s.

Our voluntary ORW`S accompany new boys to STI clinic, which makes it easier to remove their fears. An added bonus was that it was easier to assist during language problems or cultural barriers, thus avoiding misunderstandings.

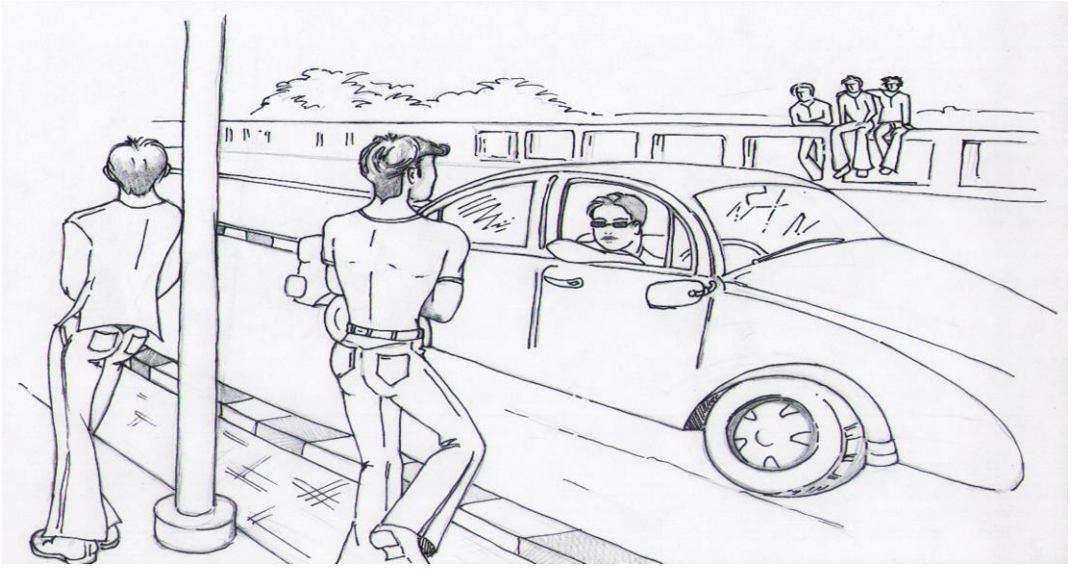
6d) SUBSTANCE ABUSE

The use of drugs became more and more important.

We realised that quite a few of the boys were using drugs like Hashish (Gard) cocaine, XTC, Speed and Cannabis. As most of them had never used these substances before in their own state, its effects could be rather strong. We are often confronted with confused and anxious young men, who were not able to deal with the effects of the drug.

It also became more and more popular among customers to use drugs like cocaine together with the MSW. The drugs are known to remove inhibitions boys it is a popular way of broadening their horizons and removing taboos and shame, and also involved a higher risk of unsafe sex.

7) PUBLIC SEX ENVIRONMENTS (PSE) & STREET WORK



Public Sex Environments (*PSEs*) is important because it is a way of reaching some male sex workers who do not use the commercial sex working scene or other social networks. Some cruising areas offer opportunities for unsafe sexual encounters, so it may be necessary to try to change peers norms and expectations in relation to safer sex.

It is also useful to hear about additional issues facing sex workers in PSEs and on the streets, such as "queer bashing" or police harassment.

Examples of PSEs include toilets, parks, lay-bys, shops, theatres, back alleys near gay bars and clubs; paths by rivers and canals; beaches; car park and truck stops; Massage/beauty-Parlour/gym/saunas and swimming pools; trains and train stations; backrooms in bars and porn cinemas, and of course the street. In short, the list encompasses any location, which offers willing participants and opportunity.

The nature of activity

Young men who work in PSEs or on the street are often opportunistic. They may be specifically in the PSE to sell sex, likewise they may have gone there to obtain casual anonymous sex with non-paying partners, and found that a paid sexual encounter has occurred. In the same way, PSEs and the street are often used by younger gay men, and gay/bisexual men who are coming to terms with their

sexuality and using such environments as places of experimentation. In so doing, such young men may be approached by older gay men who are seeking to buy sex, who may offer this younger men money or favours in exchange for sex. The young man may capitalise on this opportunity, and realise that he has the ability to sell sex, thus begin to develop sex-selling skills. Street scenes may have a local reputation for being places where sex is sold, which may the initial draw of the young men; for instance, it may be fine that some young men may actively chose to sell sex on the street or in PSEs, but not if they'd prefer to go elsewhere, but don't have the courage, money or experience to do so.

Who uses PSEs?

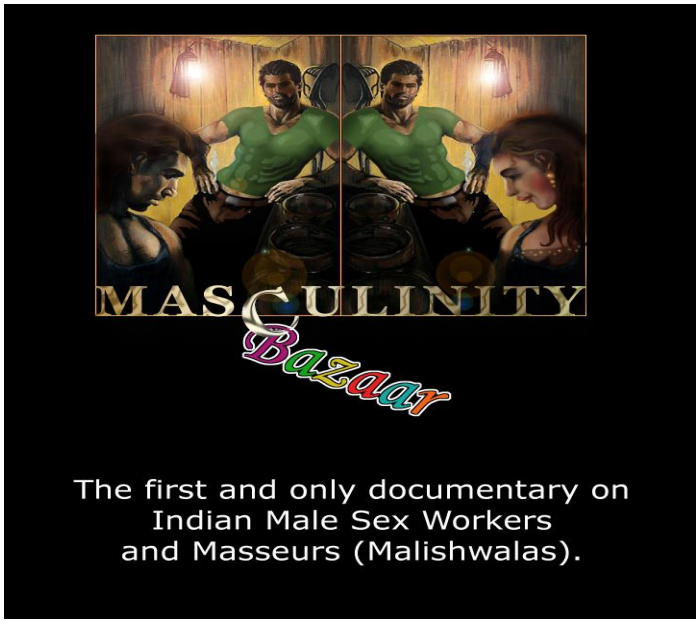
Students, unemployed men, young men, men selling sex, married men, men who don't identify as gay, older men, visitors/business, men in relationships, single/married woman – potentially anyone.

Why do men go there?

For sex, companionship, because they can't afford pubs, because they want an element of danger, because it can be anonymous with no strings attached, because this is the only access to another men, because of the unpredictability and excitement, because it's fun, because they're drunk, because they have a compulsive need for sex, because it's a no nonsense way of getting sexual fulfillment, because they are bored… as stated previously, young male sex workers may be there specifically to sell sex or cruise, usually a combination of the both!

7a) THE PRACTICAL WORK TODAY

Since the study conducted in 2001; we have developed exceptional rapport with the MSW & Masseur (Malishwala) Community, thus been able to expand our activities in the field of male sex work & Masseur community with out single donor funding to create referral for STI & HIV check up as well as condom distribution that initially involved Male condom, but have also started we have also started distributing Female Condom due as we were a part of the *Acceptability Study* conducted by *Hindustan Latex Limited –Female Health Company*, Sensitization with Police stations, support of Lawyers/Advocates; with the support of the community e have been able to accomplish another study –titled- *Sexual Behaviour of the Male and Female Clients of the Male Sex Workers & Masseurs, in 2003* ; to day we have achieved the distinction of a forging a diverse Coalition of Male Sex Workers & Masseurs (Malishwalas) spread across India the coalition is known as – *Indian Male Sex Workers & Malishwalas (Masseurs) Coalition – (IMMC)* and most significant our excellent rapport enabled us to have shot a 70 minute documentary film in November-December 2003 on Male Sex workers and Masseurs (Malishwalas) Titled "*Masculinity Bazaar*" we are exceedingly pleased to say that we are the only agency in India to do so till date.



In January 2004, concluded a cursory sex mapping of Mumbai Metro of Male Sex Workers and Malishwalas work, cruising and pick up points

8) NETWORK

Samabhavana has been successful in forming a loose coalition of Male Sex Workers and Masseurs known as *Indian Male Sex Workers and Masseurs Coalition (IMMC)*

This coalition consists of people from diverse behaviours of *Homosexual, Bisexual, Heterosexual orientation* and wide-ranging geographical working areas as Srinagar- (Kashmir), Delhi, Jaipur- (Rajasthan) Lucknow – Varanasi- (Uttar Pradesh), Chandigarh – (Punjab), Mumbai-Poona- Kolhapur- (Maharashtra), Panjim – (Goa), Hyderabad (Andhra Pradesh), Thiruvanthapuram-Calicut-Cochin – (Kerala)

8a) BACKGROUND

In India, male sex work is a non-issue, ignored by policy makers, funders and service providers. Influencing factors such as migration (especially from rural to urban cities) and mobility make it increasingly necessary to exchange information across the borders and to develop specific strategies and services which target the specific needs of male sex workers.

8b) The reasons for being part of a network:

The answer to this question will define our position when considering the option of creating or participating in a network. It will show our needs, strengths and weakness to be shared with the rest of the members of the coalition and implies a previous analysis of our organizational resources

Following are some of the reasons to belong to a coalition

- We cannot work in all areas of activity
- We cannot cope with all the local, state and national areas
- There are certain services that we are not able to support
- The wish to exchange experiences

- To create a lobby
- To create synergies between organizations
- Economic reasons (better option to get funding)
- The sex work also works through network

Male sex workers are confronted with specific problems and various forms of discrimination. The taboo on homosexuality and prostitution leads to further marginalisation.

Experience shows that specific service provision for male sex workers is the exception rather than the rule. Many services have contact with male sex workers, but do not recognise their specific needs or even acknowledge their identity as sex workers.

The perceived small number of boys and young men selling sex to men, and the taboos on male sex work, combined with the difficulties of receiving funding, discourage agencies from developing specific services in this field.

Therefore agencies need to be informed in order to become more aware of the needs of male sex workers, who might use their services as well.

Each state and cities has specific issues and problems unique to its location.

Prostitution itself, as service provision, is influenced by the socio-economic context of each State.

This makes it necessary to develop specific methods, focusing on the state/district and local needs.

Networking needs to be developed at national and regional levels in order to stimulate mutual support and improve service provision for male sex workers.

Male sex workers are a heterogeneous group with different needs. Agencies need to develop different services in order to reach different groups. Cooperation at local and national levels is required and other services should be involved and informed as well (e.g. gay organisations, services for people living with HIV and AIDS, services for young people, drug users, homeless people, etc.).

The reality is that most men across India, who sell sex, are selling sex to other men. The Samabhavana principles focus on the nature of sex and sexual acts, not sexuality, therefore the health promotion theory which underpins the principles is applicable to male sex workers, even if they do not identify as gay or even bisexual (which many of them are not, especially many of the migrant sex workers), which makes it necessary to develop specific methods, focusing on the national and local needs. However, these methods can be underpinned and informed by an agreed and shared set of objectives, and these guidelines also act as a tool to help develop 'best practice' in a consistent and uniform way.

- Sensitising service providers, policy makers and funders concerning male sex work (on National and state level)
- Development and support of better access to medical and social services for male sex workers
- Development of specific activities at a National and state and Asia level
- Development of political statements for service providers and National and State governments

- Development and implementation of 'model' projects and activities, bench-marking good services model

8c) HOW IS THE NETWORK ORGANISED?

The division into Regional groups is one of the most important changes within the Network. By changing the structure of the Network, we hope to increase the involvement and the commitment of each individual partner. The similarities between the states will create intensive and effective ways of cooperation and mutual support within the regions. Each group will develop specific working plans, based on the specific needs within their region:

The Network will be focusing more on the political issues regarding male sex work. Political statements regarding the fundamental human rights of sex workers is to be developed also it is important to recognise that there is a wide diversity amongst young men that sell sex, so it should also be recognised that there is a wide diversity amongst workers project, and the project as a whole for example a group of young Heterosexually/Bisexually identifying sex workers, who, although they sell sex to men, often present with an overt homophobic attitude, a homosexual outreach worker might not be the most ideally suited worker for engagement with that group of sex workers.

Sexual identity (defining oneself as gay, bisexual, transgender or heterosexual) is a very personal issue, and some male sex workers may be reluctant to use services/projects that are perceived as being solely aimed at men who identify as gay. This may be especially true if working with immigrant sex workers (Masseurs/ Malishwalas).

8d) Internet Survey

Samabhavana has noticed an increasing number of young men selling sex to men through the Internet. Service providers have no experience with this new phenomenon and do not know how to approach this group of male sex workers. This issue has been discussed several times within Samabhavana & IMMC and we need to conduct a detailed needs assessment; the one methodology that can be used is by sending out on line questionnaires being filled on line in chat rooms, E-lists and send out to various individual emails in such e-lists and chat rooms

We have identified 167 such e-lists & chat rooms on Internet that cater to Indian clientele and have many westerners listed on it.

The *IMMC* will focus on the development of activities in the field of Male Sex Work and Masseurs Community. The following issues need to be discussed:

- Ways of funding and interventions
- Development of campaigns, to inform policy makers, funders, media and the general public

8e) Pilot Survey

The initial "KABP Study of Male Sex Workers and Masseurs in Mumbai Metro" conducted by us in 2001 identified migration as a little understood and under-researched phenomenon amongst young men selling sex across India. The Network suggested three strands of migrant male sex workers

- Men who migrate from one Zone/State, and end up selling sex in another Zone/ State

- Men who arrive from outside the District and find themselves involved in selling sex within the City.
- Men originating within city, and migrating within the state in order to find or vary there sex work or working environment.

It was felt that a strategic approach was required to learn more about each of these groups of sex workers, 'chart' their progression and try to establish factors and co-factors contributing to this phenomenon. Greater understanding would facilitate services to work with the specific problems and potential cultural challenges of these young men.

The benefits of Coalition work are:

- It brings individuals together, and people can break their isolation.
- People share experience
- It is possible to get support and advice from other group members.
- Group discussion can lead to a more profound examination of often-complex issues.
- People can be relieved to find they are not the only ones in the work who have had this happen to them/who think like that.
- Coalition can be a forum for challenging perceived notions and for promoting equal opportunities.
- People get to meet each other; they have a social function.
- Coalition can be springboard for community action, lobbying, further groups and activities – of development of a peer network.
- Coalition can build confidence and self-esteem. Though time consuming, but it is especially beneficial in the early days of a project when workers may be under confident, or when tackling a very complicated topic.

8f) MANIFESTO OF INTENTIONS:

INDIAN MALE SEX WORK & MASSEURS COALITION- (IMC)
Reason to be:

- Because of the complex industry and sex market
- Because of the mobility and migration
- Because of the invisibility of the interference with the Human rights
- Because of the need of the media for more adequate information
- Because of the partial knowledge of the reality
- Because of the lack of social sensitizing
- Because of the diversity of answers

9) OUR FIRST STUDY WAS CONDUCTED IN OCTOBER 2001 ON: -

KNOWLEDGE, ATTITUDE, BEHAVIOUR, AND PERCEPTION (KABP) TOWARDS HIV/AIDS – A STUDY AMONG THE MALE SEX WORKERS AND THE MASSEUR COMMUNITY IN MUMBAI

AN EXECUTIVE SUMMARY

The study was undertaken by *Samabhavana society* in 2001 and thereafter disseminated the same to various agencies, this was the first time again that the target population was present in full strength

Aim of the study was to understand this highly mobile and invisible group in the sex work sector is the Male sex workers and malishwalas (masseurs) who are very active in the Mumbai metropolitan city.

These sex workers, who are present in every strata of society, are the ones who get paid in the form of money but may also render services for kind.

There was an indication of the group indulging in high-risk sexual behaviour and hence the need for studying their Knowledge, attitude, behaviour and perception with regard to HIV/AIDS, before beginning any intervention

Informal discussions indicate that most of the malishwalas (masseurs) are paid for the services rendered for massage but *double up* as sex workers for which they get paid extra or in kind. Condom negotiation is not prevalent and many a times the Clients insist on non-use of condom.

The Knowledge, Attitude, Behaviour, Perception (KABP) towards HIV/AIDS was conducted amongst Male Sex Workers & Malishwala community and its sub segments in Mumbai metro.

The study was perceived when condom distribution was being done over a period of three months and feedback of condom usage via an in depth interview (IDI) conducted with five such sub groups of male sex workers. The setting was informal and the discussion format was completely free flowing. Discussions were held on one on one basis and some times in groups of twos and threes.

It was perceived that in spite of condoms being made available periodically there was no condom negotiations skills present. The setting was such that the MSW could not negotiate the price and sex was a part of a ritualistic massage practice. It was also reported that sexual abuse and unprotected group sex was a norm.

The targeted group was Male sex workers (MSWs) and Masseurs (malishwalas). The sub-segment found amongst them where the *bazaar boys*, *beauty parlour boys*, *sex network of MSWs controlled by pimps*, *educated young men from the modeling/film industry* and some such *College boys* who would do it for extra pocket money.

It is clear that the HIV pandemic in India, as specifically extrapolated from the Mumbai metro scenario has a subterranean homosexual-MSW content and that; this unprotected male-to-male transmission is not being addressed.

Any future interventions with this group would have to be focused on the following objectives:

- To motivate MSW and Malishwalas to adopt safe sex practices and to reduce high risk behavior
- To introduce condom negotiations skills.
- To provide high quality STI services at government hospital and/or enable MSW`s and malishwalas to seek other appropriate services through a system of referral linkages
- To provide a safe space and a non-judgmental meeting ground for MSW and malishwalas to participate in group discussions on safe and healthy sexual behaviors
- To develop a model for continuum of care for MSW and malishwalas who are HIV positive

In order to begin interventions on the above, it was necessary to understand the community better and hence the need for the study.

Objectives of the study:

- To study their knowledge regarding HIV/AIDS
- To gauge their attitude towards positive people and HIV/AIDS in general
- To study their sexual behavioural practices
- To understand accessibility of condoms from their perspective
- To study the psychosocial factors that compel them to sexual abuse

Methodology: A structured questionnaire was developed which encompassed all the relevant issues to be addressed. Data collection started after a good rapport was developed with the target audience. Data was collected at a time and place most convenient to the subjects. Prior to collecting information, the study participants were briefed about the reason for this exercise. A verbal consent was taken from each of them. A total of 120 MSWs were interviewed. The data was thoroughly cleaned and coded before running the analysis in SPSS. The findings of the study follow:

DEFINITION: *Male sex-workers are defined here as those males who engage in sexual activity with other males or females for the primary purpose of immediate financial and or material gain and the person completes the transaction and such transaction is his source of income.*

1.0 Socio-economic profile of the subjects

- The Median age of the respondents is 21 years.
- Thirty percent have never been to school. However, of these, more than half (16%) are illiterate. The others can sign or are functionally literate. Of those who have been to school, 48% have studied up to high school (10th std.)
- The marital status of the target group shows that 43% are married.
- While about 55% reported working as masseurs, their only occupation, 21% reported other service besides being a masseur. Seventeen percent were unemployed with no source of income at the time of the survey.
- Analysis of the monthly family income indicates that 32% earn up to Rs. 3000 per month, 40% draw up to Rs. 6,000 per month, while14% draw more than Rs. 8000 per month.
- While about three-fifth of the respondents stay with their friends, one-fifth stays with their parents and siblings. Nine percent live with their wife and children while 12 % live alone.
- With regard to their domicile profile, only 13% belong to Mumbai. The rest belong to the northern regions (67%) including the States of UP and Bihar, very few from the southern State of TN and some from Srinagar (1.7%), Andhra Pradesh (1.7), Gujarat (1), and Jammu (1).

2.0 Knowledge about HIV

- About 38 % perceived HIV as a foreign disease, 27% related it with death, 16% reportedly knew HIV as a microorganism that causes AIDS while the remaining described it as an insect
- With regard to how HIV is transmitted, 1 (29.2), 2(89.2), 3(78.3), 4(80.8), 7(20%), 8(21%), 9(24%),
- Prevention of transmission of HIV: 1(29.2), 2(86.7), 3(64.2), 4(48.3)
- Only 7% reported knowing of treatment for HIV

3.0 Knowledge about AIDS

- About 14% knew of AIDS as a condition where the body's immune system breaks down. About 62% reported AIDS to be a killer disease. About 17% were ignorant of AIDS while about 7% reported AIDS to be a deadly virus (6.7).
- Perception of AIDS: Majority perceived AIDS as "Death", 9 % did not know how to perceive it and 1% perceived it like a disease
- Of those who knew or had heard of AIDS, 95% felt that there was no cure for AIDS.

4.0 Substance use

- More than half the respondents (53%) reported consuming liquor/alcohol before sex. Of these, a majority (64%) reported consuming it occasionally. An equal number reportedly consume gutka/mawa, etc.

5.0 Sexuality

- When asked whether they had indulged in sex with other men in the last one month, 76% reported this frequently (defined as more than five times in a month). Only one respondent reported to have never indulged in such activity.
- The average number of sex partners in the last one-month among those who reported having had sex during this reference period is 11.
- Average number of female partners in the past one-month is 2. Of those who indicated having sex with female partners in the last one month, the average number of times this was done is 5 times.

6.0 Practices pertaining to sex

- While 17% reported never to have indulged in wet kiss with their partner, the rest reported this act either frequently or occasionally in the past one month.
- With regard to mutual masturbation, again 17% reported never having done this behaviour with their partners, 48% reported indulging in this behaviour frequently, while the remaining indicated this being done occasionally.

7.0 Oral Sex (Peno-Oral)

- About 78% reported indulging in peno-oral sex, of which one-fourth indicated regular behaviour of this kind.
- When queried about condom use by partner during oral sex, only 17% reported in the affirmative. However, consistent condom use was reported by only 8%.
- 84% respondents let another person suck/lick their penis in the last one-month and only 16% condom use was reported, of which only 9% regular and consistent condom use.

8.0 Oral sex with male partners (oral-anal sex)

- About two-fifth reported oral sex with male partners in the past one month, 8% frequently (defined as more than 5 times in the past one month)
- Except one respondent none other reported their partner to have used any protection like a condom dam

- Two-fifth of the respondents also let their partners have oral-anal sex with them, 14% regularly. Here too, except one respondent; no one had used any kind of protection.

9.0 Peno-anal sex

- A majority (92%) of the respondents had inserted their penis into another person's anus in the past one month, of which 57% indulged in this behaviour >5 times during the period. Here too, 40% used a condom, 21% consistently while the rest occasionally.
- A little less than half (48%) the respondents reported having their partner's penis inserted into their anus during the past one month. Again, 32 % reportedly used condoms, of which only 18% reported the same regularly.

10.0 Sex with female partner

- 56% have had sex with female partner since the last one-month. Of these 17% reported this more than 5 times in the past one month. Eighteen percent reported having used a condom but only 8% reported using it regularly.

11.0 Partner seeking

This section indicates where the respondents met their sex partners and the place where they indulged in sexual activities.

- As reported through the study, the first contact with the partner was friends as reported by about one-fourth of our respondents. A majority of them were a part of a sex network (70.8%) through which they met their partners. One-fourth of them also reported first contact with sex partner at the Chowpatti beach, With regard to the usual meeting place of the sex partner, 29% reported beaches; about 6% reported that they had clients with reference of known people. Other places mentioned during the interviews were restaurants, and bars, bazaars, Gateway of India, beauty parlours and Parties.
- The place where sex takes place is mainly enclosed areas like Home (60%) and hotels (66.7). The other areas include beaches and inside cars
- Almost all of them (97%) mentioned that they indulged in sexual activities in exchange for cash/kind

12.0 Sexual health

Questions were posed with regard to their sexual health and indications of Sexually Transmitted Infections. The reference period here was the past 6 months.

- About 24% suffered from STI's in the past 6 months. The symptoms of the problem as reported by the respondents are redness and swelling of groin (4.2%) and intense itching in genitals (13.3%).
- Almost 80% have taken treatment for the problem. Systems of medicine used for treatment are Unani (48%), Self medication (17.2%), Allopathy (20.7%), Homeopathy and Ayurvedic (6.9% respectively).
- Thirty two percent of the respondents have undergone HIV testing. However, they all refused to mention where they went for it.

13.0 Availability of condoms

- One third finds it easy to access condoms.
- Reasons for condoms not being accessible are too costly (27.5%), Not available near cruising place (60.8%), Clients don't have it during sex (68.2%), difficult to store (45%) and do not get it late in the night (3%),
- None of them knew the correct steps of wearing a condom.

14.0 Care and support towards HIV +ve persons

- About 36% do not mind breaking off their relationship on learning of their partners' +ve status. The rest will maintain and continue the relationship. Majority 53% said that they would maintain contact so as to help their partners as and when required
- Majority of the respondents perceived a person who suffers from HIV to be near to death and that they feel sorry for the person.
- Kind of support services that needs to be developed for the MSWs who are HIV +ve are: HIV testing facilities (67%), Counseling facilities for prevention (73%), counseling facilities for +ve (71%), hospices for, +ve (89%). Infact, they requested the interviewer to give more information.

15.0 Psycho-social problems

Questions with regard to whether they were ever forced to have sex with another person, sexual abuse and assault were asked.

While 27% reported having been forced to have sex with a man frequently
About 89% were force to have anal sex while 10% reported being forced into oral sex with another man.

A majority (92%) reported having undergone mental/physical trauma in their relationships. On probing deeper, the following responses emerged: "I was physically beaten, had a fight with him because no money was paid", "felt anger and frustration and felt like beating him but since he was a client it would be bad for business", "Felt dirty and angry and insulted", "He was a policeman and was forcing me to have sex with him", "I was bleeding and burned with cigarette butts".

9) OUR SECOND STUDY WAS CONDUCTED IN 2003 OCTOBER:

Sexual behaviour of Male Sex Workers & Masseurs with their Male/Female clients/partners in Mumbai, Maharashtra

Conducted by: Samabhavana Society

Abstract
The objective of this Study is primarily explorative and also to describe the risk behaviour of Male Sex Workers & Masseurs who predominantly serve male clients as well as service the Female clients/partners in Mumbai, Maharashtra to discuss implications for the spread of the disease, and to discuss appropriate interventions for these group.

Data is drawn from a qualitative study of the workers and clients consisting of interviews with many open-ended questions. The results of the study are viewed in terms of the AIDS Risk Reduction Model (ARRM). The data indicates that there is a very active community of male sex workers and male/female clients in Mumbai that is at risk of AIDS infection. Multiple sexual partners, unprotected anal/ vaginal intercourse, and frequent experience with STDs put both workers and clients at risk.

Workers had knowledge of AIDS and STDs, although clients were mainly well informed.

Both groups were characterized by frequent mobility. High levels of alcohol and non-intravenous substance abuse use by clients and in course by the male sex workers were reported before and during sexual encounters and may be a factor in increasing risky sexual behaviours. Interventions for these groups should include improving knowledge of workers, improving STD treatment for both clients and workers, skills training for sex workers, and increasing availability of good quality condoms and lubricants.

Introduction

Samabhavana Society has been working with this population of Male Sex Workers and Masseurs community for more then three years without a single funding support and voluntary staff is doing all its work from the community of Male Sex Workers and Masseurs.

Samabhavana networked with Male Sex Workers & Masseurs Community in other cities of India- namely; Hyderabad, Bangalore, Thiruvanthapuram, Panjim, Delhi and Lucknow-Varanasi and actively seeking other such networks in other parts of the country and allied with NIMSW

In course of our work, we have tried to do advocacy with various funding agencies in Mumbai to start a specific targeted intervention with this population, but we still do not have a single project from any agencies.

This study was motivated after the secretary Mr.Jasmir Thakur`s visit to Bangkok which we are very grateful to SHRC-DFID for having supported us to attend Asia Pacific Regional conference on Reproductive and sexual Health and the chance it give to interact with Male Sex workers (go –go boys) in Bangkok

Background

As per NACO- the point estimate for year 2001 comes to 3.31 million HIV infections in adult population (15-49 yrs. age group) in the country. With a 20% variability to take care of unaccounted numbers of IDUs, MSM & other age groups. In the same report on MSM they have found More than half the respondents (57%) said that they usually traveled to other places, of whom, 17% said that they traveled at least fortnightly. About 20% respondents said that they traveled out at least once in a month. These trips were usually meant for socializing with relatives / friends (47%) or for pleasure (27%). Around two-thirds (67%) of the respondents reported ever having consumed alcohol. Nearly 16% consumed alcohol everyday followed by 35% who consumed at least once in a week and 28% who consumed once a fortnight. More than one-third (36%) regularly took alcoholic drinks prior to sex Intoxicating drug use was reported by nearly 13% of the total respondents. Of them, about three-fourths (76%) reportedly tried Ganja, 42% mentioned Bhang, 8% had tried Afim and consumption of brown sugar and heroin was reported by 4% each. A significant

proportion (12%) had also reported injecting addictive drugs without a medical prescription within the last 12 months.

It is clear that the HIV pandemic in India, as specifically extrapolated from the Mumbai metro scenario has a subterranean homosexual-MSM content and that; this unprotected male-to-male transmission is not being addressed there is much concern about the role that Male Sex Workers may play in the spread of HIV infection, boys/men/male involved in prostitution run the risk of rape, violence, drug abuse, STI infections including HIV/AIDS, and even death. They frequently face harassment and are stigmatised by their communities, particularly if it becomes known that they are having sex with men. Due to the fact that homosexuality is considered socially, culturally and even legally unacceptable in India, those boys/men/males that have sex with men – whether they are homosexual or not – are commonly branded as such. In India, the subject of homosexuality is strictly a taboo for religious reasons. Those involved in homosexual activity are often described as "perverts" and homosexual acts usually violate "public nuisance" laws.

There are no programmes that address Male prostitution in India. Most interventions in India that do address this target group are related to HIV/AIDS awareness work. As there is no targeted intervention till date and the MSM interventions are not equipped nor sufficient to address this population which is very migratory in nature and is based on power structure of financial negotiations as well as reeling from double stigma of sex work and homosexuality.

Samabhavana realizes that there are still many challenges in addressing Male prostitution. Over the past several years, Governments, IGOs and NGOs in South Asia have been aware of the problem of CSEC in their countries. Funds have been allocated to implement projects that combat CSEC, especially trafficking in women and children - on which a number of research studies have been conducted. However, there is limited interest in collecting data or conducting research on Male prostitution, trafficking, migration and funding agencies & policy makers often overlook the problem.

Additional situational analyses and research on Male prostitution should be conducted, so that appropriate interventions can be designed.

It's important to know that how the sex industry at large does affects the involvement of Male Sex Workers and Masseurs?
The sex industry in Mumbai and for that matter India has undergone major transformations during last 4-5 years. The growing phenomena of massage parlor in metro cities, the effect of globalization, worldwide Internet easy access, and increasing areas for nightlife change a lot of Mumbai youth's regular life and Mumbai is also known as the Mecca of Migrants – A place were dreams are realized and with added glamour of Bollywood. Prostitution is illegal in India, but the law enforcement agency and administration's crackdown has typically focused on the visible side of the sex industry and street prostitution i.e. Female, leaving the higher-status and discreet escort services and massage parlors relatively untouched. And surprisingly administrations has information about Male sex work in Mumbai but they do not crack down, as there is no reporting of underage male child being trafficked or coerced, Now the Male Sex workers and Masseurs have turned to using the Internet, pagers and cellular phones to conduct their business, the industry is growing even as fewer Male Sex Workers work the streets, partly because of the anonymity, relative safety and low cost of using the internet/mobile to set up appointments and transactions.

Our estimation shows that in Mumbai city there are more then 100 massage parlor and escort service center and majority of this provide male-to-male service. The major English newspapers display the advertisements of massage parlors and hotel/home service in Mumbai as well as any other Metro cities. In working days the number of displayed advertise are 8-10, where in weekdays it becomes 15.

Although the literature on female commercial sex workers has become fairly large, there are no published reports on male workers who serve male/female clients in India.

But some data was available from studies conducted in the United States (Fowler 1989; Pleak and Meyer-Bahlberg 1990; Estep, Waldorf and Marotta 1991;Waldorf and Lauderback 1991), in Europe (Tirelli et al. 1988; van de Hoek et al. 1988; Robinson, and we did rely on Men who sell sex by Peter Aggelton

This study project is an effort of Samabhavana Society; Financial support for this study was provided by Samabhavana Society. Our teams of volunteers have assisted with this study

MALE SEX WORKERS & MASSEURS AND MALE/FEMALE CLIENTS/PARTNERS IN MUMBAI

The most comprehensive study conducted in Mumbai was by us in 2001, had found that in a sample of 120 MSW and Masseurs that male sex workers & masseurs had considerable knowledge about AIDS and this knowledge was not related to their behaviour.

They often tried to avoid anal intercourse and have now started frequently using condoms if they did engage in anal intercourse, particularly with clients. Condom usage was neglible (at that point - 2001) & (only 6% used and none knew the correct condom wearing steps) for anal intercourse, although many encounters involved only other sexual activities. Workers felt safest in sex with male customers (regulars), less safe with other male partners (non-regulars), and least safe with female partners (casual).

Most male workers reported that they engaged in anal intercourse without protection. The low incidence of condom usage was a result of negative prior experiences with condoms including breakage, small size, customer refusal, or discomfort. Inappropriate lubricants including body lotion, oil, and saliva were also used.

These men had a large number of sexual contacts and more than half engaged in insertive and receptive anal sex without condoms. In the two-week period before the interview, all workers had sex with male clients, 13 per cent with non-client males (regulars), and 50 per cent with male client only 2 had sex with female clients but about 75% had sex with casual female partners (girlfriends/prostitutes). Thus, the sexual activities of these young men put them at risk for HIV infection and the potential for spread of the disease was high because they have sex with both male and female clients and non-clients.

Study context

At the end of 2002, the currently documented number of AIDS cases and HIV-infected persons in Mumbai was comparatively low but still alarming as per the population of this island city: NACO & Ministry of Health has conducted Sentinel Surveillance with particular emphasis on high-risk groups including female

commercial sex workers but in this group there is no sample of Male Sex Workers as well as Masseur community a group identified as the highest occupational group by a study conducted by IMRB for FHI In Mumbai (study yet to be disseminated-Samabhavana was a part of this study) given the estimated large numbers of sex workers in India and their suspected high rates of sexually transmitted diseases (STDs), there is a great potential for the spread of HIV infection.

Mumbai is an island with a population of nearly ten million people. Mumbai is also the business capital and the most well connected transit point, thus, considerable circular migration to and from Mumbai occurs, consisting of business people and tourists from India and beyond, as well as the poor searching for employment.

The commercial sex industry exists throughout India and can be found throughout the Mumbai city.

Commercial sex is illegal throughout India and the law is periodically enforced in Mumbai by means of token arrests and deportations of female sex workers to their homes. Male sex workers have generally not been subjected to such arrests. Although the number of female commercial sex workers in Mumbai is estimated to be over 50,000 the total number of male sex workers in Mumbai is estimated to be more then 2000 as we have been able to outreach over a period of last three years around 2000.

Transgenders known traditionally, as Hijras are visible and in Indian cities. The Hijras traditionally have been known to go house-to-house seeking alms or dancing at weddings and childbirth as well as sex workers. However, apart from this group, homosexuality is generally not accepted in India and persons who reveal that they are homosexual are subjected to discrimination. They tend to be ridiculed in films and in the media and in general only successful persons in the arts and entertainment industry are open about their sexual orientation and that to not many.

The objective of this paper is to use data from a qualitative study to describe the AIDS knowledge and risk behaviours of male sex workers who serve predominantly male clients in Mumbai; to discuss implications for the spread of the disease, and to discuss appropriate interventions for these groups. The results of the study will be viewed through the framework of the AIDS Risk Reduction Model (ARRM).

This study focuses on the population in Mumbai who serve local, national and international clients. Several methods are used to meet customers: approaching potential customers in particular areas along the beach, soliciting partners on the street, going to residences, and meeting in bars, nightclubs and discotheques. Sexual relations may take place along the beach in the bushes, in the clients' hotel rooms, cars or in the rooms of cheap hotels rented specifically for the purpose. Liaisons are often brief, but many become extended with the client providing room and board, clothes, jewellery, presents, and travel rather than direct payment to the worker. In general, this Male commercial sex is not organized

The AIDS Risk Reduction Model (ARRM)

The ARRM is a three-stage model that characterizes people's efforts to change sexual behaviours related to HIV transmission (Catania, Kegeles and Coates 1990). The model aims to understand why people fail to advance over the change process, in order to gear intervention programs to a specific stage of the change

process. The first stage of the model involves labeling behaviours as high risk for contracting HIV and implies knowledge of the disease and belief that the individual is at risk of the disease. The second stage is a decision-making stage: individuals must evaluate the costs and benefits of changing their behaviour and whether they are capable of carrying out that change (self-efficacy).

The third stage is the enactment stage. This stage often includes information-seeking behaviour and requires communication skills with sexual partners. The model is used here to identify the stage of behaviour change of sex workers and clients in order to discuss appropriate interventions for both groups.

Methodology
Subjects
A convenient sample of 9 male sex workers, 11 masseurs and 14 of their clients total (12 male clients, 1 female client and 1 casual female partner) 34 persons were recruited at places where MSWs & Masseurs work including beaches, street areas, bars, or discotheques. Clients were recruited for the study either by meeting them at MSWs' work sites or at bars or discotheques where MSWs recruit clients.

Survey instruments
The interview consisted mainly of open-ended questions and assessed: (1) knowledge of AIDS, sexually transmitted diseases, and condoms, (2) socioeconomic and demographic characteristics and migration history, (3) sexual experience, including experience as a sex worker and experience with intimates and other unpaid partners, (4) attitudes and beliefs about condoms, and (5) other health practices. This open-ended free-response format has been recommended to identify beliefs and social norms most likely to influence behaviour (Ajzen and Fishbein 1980) and to identify constructs most likely to influence behaviour (Higgins and King 1981; Bargh 1984). Separate questionnaires with similar content were used for the workers and clients and in the presence of the respondents.

Interviewing procedure
The interviewing staff consisted of two persons. The interviewers were Mr.D.K.Shenoy and Mr.Jasmir Thakur - President and Secretary who have developed excellent rapport with the Male Sex-Worker & Masseur community over the last three years. Recruitment of MSW/Masseurs and their clients/partners was done by the volunteer outreach workers. They conducted all of the interviews with MSWs & Masseurs in Hindi/English language.

Mr. Shenoy & Mr.Jasmir conducted the MSW/Client interviews in English/Hindi.

Interviewer are trained persons having experience of conducting such interviews and well versed in the knowledge of AIDS and STDs. Interviews were held at locations throughout the various cruising areas including homes, beach areas, hotels, and restaurants. Locations were chosen to insure privacy during the interview. Respondents were willing to answer the sensitive questions in the interview and no significant problems were reported by the interviewers.

Basic Profile:
The target group comprises of five-sub segment of Male Sex Workers- such as
1) Malishwalas (Masseurs) / Bazaar boys
2) Beauty Parlour boys/ Gym boys (masseurs/physical trainers/sauna or steam room attendants)
3) Gigolos- Strip tease dancers/ College boys for extra pocket money

4) Modeling-film industry extras- strugglers
5) Male Sex Workers- network controlled by pimps.

We distinguish several kinds of prostitution by looking at the places where the boys meet their customers:

1) Street prostitution (Masseurs)
2) Bar prostitution (pubs) (Gigolos)
3) Club- and brothel prostitution (Strip tease dancers/ Massage parlors)
4) Escort services through Newspaper, Internet and Mobile networks (Male Sex workers/ College boys/Film & Modeling extras)
5) Prostitution in the common gay-scene (from all above sub groups)

The boys have sex with their customers at different places:
Areas of Operation:

Street Male Sex Work
- Main station
- Car
- Hotel
- Toilets
- Streets
- Sex-cinemas
- Cruising-area

Bar Male Sex Work
- Bars, esp. for prostitution

Clubs- and Brothel Male Sex Work
- Clubs
- Brothels

Escort services
- News paper/Phone calls /Internet- visiting
- Flats/apartments
- Hotels

Male Sex Work working in the common gay-scene
- Gay-clubs and bars
- Gym-sauna
- Swimming pools
- Gay parties

Male sex workers
Demographic characteristics:
The age of the male sex workers & masseurs interviewed ranged between 18 and 25 years with a mean age of 22.7 years (Table 1). One is married. All had attended school with the majority having attended at least some primary level education school and an additional 20 per cent having at least some university or academy-level education. The workers were likely to come from middle-class economic backgrounds.

A majority had fathers who were farmers or petty traders, and equal number had fathers who were either in private service/clerical jobs or in business. About 80 per cent of the workers were not originally from Mumbai and most had arrived within the last four years. The majority of the boys were Hindu

The workers were characterized by considerable mobility within India as well as outside the state as per their nature they are the biggest occupational group.

Table 1
Demographic and socioeconomic characteristics of male sex workers (N=20)

Age: *Range 18–25*	
18–21	6
22–24	7
25–30	0
Living arrangements:	
Alone	3
Other sex worker	8
Family	8
Other	1
Education:	
Primary High school	11
High school (SSC Pass)	6
College/University/academy	3
Father's occupation:	
Farmer/petty traders	9
Pvt Jobs/clerical jobs	9
Business	2

In Mumbai, 80 per cent reported living with other male sex workers & masseurs, Workers reported spending much of their free time with friends who were also MSWs. three respondents reported having other regular employment in addition to sex work. Of these, nearly half worked as Masseurs in clubs, private homes, Gymnasiums and unisex beauty salons. Eighty-five per cent reported that they would like an alternative occupation such as work in the office or car driver-tourist, self owned business, modeling, or anything as long as it is a 'good' type of work.

AIDS knowledge
During the interview, workers were asked a series of open-ended questions about AIDS. All of the workers had heard about AIDS and the major sources of information were organizations like Samabhavana, its volunteers (85%), train and Bus posters (75%), Advertisements like *Balbir Pasha Ko AIDS Hoga kya* (100%) and clients (40%). When asked who can get AIDS, the most common responses were Prostitutes (85%), male sex workers serving female clients (50%). Other answers were that one could get AIDS by having sexual intercourse with Men (unsafe Anal Sex) and with frequent partners. Only 15 per cent specifically mentioned anal sex.

Eighty per cent reported that it was possible to tell by looking if a person had AIDS, indicating that they do not recognize asymptomatic infection. Reports of symptoms of AIDS infections were often inaccurate. The majority of sex workers (55%) felt that they were at risk of getting AIDS. The most common reason given for risk was 'frequent sex with clients' (73%). For those who did not consider themselves at risk, the most common reasons were that they use condoms (75%) or that their body was healthy (50%). The most frequent responses were that they use condoms (60%) and that they select 'clean' clients (40%).

Sexually transmitted diseases
Sex workers were asked a similar series of open-ended questions concerning their knowledge of and perceived risk of other sexually transmitted diseases (STDs). All respondents reported knowing of at least one STD with 90 per cent mentioning syphilis, 90 per cent AIDS, and only 35 per cent mentioning gonorrhea. Most reported either other Samabhavana- volunteers or clients (80%) and Doctors (80%) as their sources of information concerning STDs while 35 per cent reported clients. Although most sex workers had heard of one or more STDs, their knowledge of the specific symptoms associated with these diseases and the mechanisms of transmission were often inaccurate.

Nearly all (95%) considered their clients to be at risk of getting an STD, while 70 per cent reported female sex workers. A wide variety of responses were mentioned when asked how those at risk can get an STD. Thirty per cent reported frequent sexual partners to place one at risk, 20 per cent mentioned not taking care of oneself, 15 per cent not selecting *"Proper"* partners, and 15 per cent having sex with female sex workers without condoms. Anal intercourse (15%) or oral sex (15%) was also mentioned as placing one at risk of an STD. The majority of respondents (95%) considered themselves to be at risk of catching an STD, with 50 per cent reporting their having numerous or frequent partners as the reason, while 13 per cent reported having sex with female clients as placing them at risk.

These sex workers considered both male and female clients (95%) as people likely to have STDs while 55 per cent specifically mentioned gay (kothis/transgender) sex workers as people who suffer from STDs. A variety of alternative approaches to prevention of STD were reported. Forty-five per cent of the respondents stated that they had used a condom to prevent transmission while 35 per cent mentioned careful selection of partners, ten per cent applied *"Dettol"* after sex, and ten per cent avoid anal sex. Half of the respondents reported that they had ever had an STD. Of these 90 per cent reported having an STD two or more times. Sixty per cent reported self-treatment with various drugs while 40 per cent had visited a doctor for treatment at least once. Informal conversations with workers revealed reluctance among some to visit government health-care providers because of the stigma of their homosexual activity.

Condom beliefs and general condom use
A series of open-ended questions were asked to elicit condom beliefs from workers. In response to questions about the 'good things' about condoms, the workers replied that they were safe and they prevent diseases (60%), they are clean (30%) and they prevent pregnancy (30%). 'Bad things' about condoms were that they decrease pleasure. They also said that men with frequent partners should use condoms (56%). Ninety per cent thought that condoms prevent AIDS and all knew of sources for condoms in Mumbai.

Ninety-five per cent of the workers had used a condom in the last month with the main reason for use being to prevent illness. Seventy per cent keep them at their residence and sources for condoms include the pan shops, chemists (43%), clients (29%), and Volunteers and peers (95%). Almost all workers had discussed condoms with clients and many claim to ask clients to use condoms. Twenty-four per cent reported that they ask all clients to use condoms, 24 per cent ask those who they do not know or who look suspicious, 35 per cent ask all female clients; Seventy-two per cent have had clients who refuse to use condoms.

General sexual history
Most of the workers first had sex with a man when they were in their teens: 35 per cent at age 14 or less, 40 per cent at age 15-16, and 25 per cent at 16 or more. Forty-five per cent of the workers were paid for their first sex with a man. Eighty-nine per cent have had sex with a woman. Respondents had worked for an average of 3.1 years with a range of two months to four years. The workers generally return to their home village for holidays (85%), and all are usually sexually active on these visits. All of these men interviewed identify themselves as Heterosexuals in spite of having most sex with men, when asked why not homosexual they said "*pet ke liye karna padta hai"*(For eating they have to do it)

Most workers work seven days each week and most have one client per day with a reported average of 5.9 clients each week. The median earnings per week were Rs.1000 and the range was from Rs.400 to Rs.5000. In addition to cash, most workers also receive non-monetary payments such as food or clothing.

Workers report having clients who include Married men (100%), gay men (85%), and tourists (90%), as well as businessmen (80%), wives of male clients (45%), Female clients (43%). Nearly all (95%) report being with clients both for a short time and all night but 72 per cent report that they are with most clients for a short time.

Table 2 shows the frequency of sexual acts requested by clients and the percentage of workers who agreed to perform each of these acts. Anal intercourse, both insertive and receptive, was the most common act requested and almost all workers would agree to perform these acts except being receptive partners until and unless they got paid more. Masturbation of the client and the client masturbating the sex worker was the next most frequent practice and all workers would agree to this practice. Oral intercourse followed, with almost all workers agreeing to perform. Rimming, tongue to anus, the last practice asked about, and was less common.

Table 2
Distribution of male sex workers according to frequency of clients' requests for various sexual acts, and number of sex workers agreeing to perform acts (N=20)

Sexual act	Initial reluctance	Number agreeing
Client sucks sex worker's penis	None	19
Sex worker sucks client's penis	None	19
Client's penis in sex worker's anus	50%	17
Sex worker's penis in client's anus	None	19
Client licks sex worker's anus	None	16
Sex worker licks client's anus	100%	0
Sex worker masturbates client	None	19
Client masturbates sex worker	None	19

Sexual experience in the last week
Workers were asked detailed questions about their sexual experience in the last week. They had an average of 5.2 clients in the last week, with 4.1 of these new clients and 0.8 repeat clients. Two workers reported new female clients in the last week. Forty-three per cent of the workers had an intimate female non-paying partner (girlfriends) and 32 per cent had a casual non-paying partner (sugar daddy). Sixty per cent of workers had sex with female partners at the instance of the male client, 20 per cent had female clients

Table 3

Sex workers' experience with oral and anal intercourse in the last week (N=20)

Sexual act	**Number times with client**	
Partner inserts penis in sex worker's:	Anus with condom	**8**
	Anus without condom	**4**
	Mouth with condom	**0**
	Mouth without condom	**18**
Sex worker inserts penis in partner's	Anus with condom	**15**
	Anus without condom	**14**
	Mouth with condom	**0**
	Mouth without condom	**20**

Table 3 shows the frequency of experience with oral and anal intercourse in the last week for sex workers. Most workers had experienced insertive and few had receptive anal intercourse and many episodes took place without condoms. Oral intercourse was also a common practice and there was almost no condom use for oral intercourse.

Male/female clients of sex workers
Demographic characteristics
Male sex workers report that their clients include local, national and international clients who are males and females. This study includes only one female clients who is a resident engaged in a variety of business activities. These clients reported permanent residence in Mumbai, 21 per cent from other states like Delhi, Bangalore, Hyderabad, Jaipur, Baroda and Goa (Table 4). Their age ranged from 23 to 53 with a mean age of 34.8 years. One-third of respondents are currently married to a woman. Respondents tended to be highly educated 70 per cent having attended college or university, and an additional 16 per cent having received a postgraduate degree. As a group they tended to be frequent travelers, with almost 80 per cent of those 21% having previously visited Mumbai. This latter group consisted primarily of people engaged in business activities who made multiple visits. Most respondents were traveling alone. Many men had visited other cities in the India in the last six months.

Their occupations included business, designers, artists, cab drivers, and other professional and non-professional occupations.
(12 male clients, 1 female client and 1 casual female partner)
Table 4
Demographic and socioeconomic characteristics of male/female clients of male sex workers

Age Range 23–53	
Less than 30 (includes female partners)	**6**
30–39	**6**
40+	**2**
Travel status:	
Alone	**6**
With friend	**0**
Education:	
High school	**9**
College/university	**11**
Postgraduate	**2**

Permanent residence	
Mumbai (local) (includes female partners)	**8**
National (other states)	**6**
International	**0**
Relationship status:	
Currently Married to women	**11**
Previously married to a woman	**0**
Have a male life partner now	**1**
Have had a male life partner (This includes the female client)	**2**

AIDS knowledge

The clients were also asked a series of open-ended questions about AIDS. The most important sources of information for clients were media, friends and other media including newspaper and television. They reported that AIDS could be transmitted by blood (58%), needles (53%), sex (48%), anal sex (18%), and transfusions (37%).

The majority of clients said that it was either unlikely or very unlikely (63%) that they would get AIDS. The modal reason for the low risk was careful or safe sex (45% of all clients). For those who thought that it was likely, 33 per cent gave 'risky sex' as the reason for their higher risk. Almost all of the clients (95%) reported taking actions to avoid getting AIDS and these included careful, safe sex (50%), use of condoms (50%), and having decreased the number of partners (39%).

Sexually transmitted diseases

Clients were asked similar questions concerning their knowledge and perceived risks of contracting other STDs. Relatively high levels of knowledge of STDs were observed with 90 per cent of respondents mentioning syphilis and gonorrhea, and an additional 80 per cent adding herpes genitalis.

Most frequently mentioned symptoms of STDs included dysuria (53%), discharge (47%), sores on the penis (37%) and swelling of the genitals (32%). Respondents thought it likely that male sex workers in Mumbai suffered from STDs with 53 per cent mentioning AIDS, 37 per cent gonorrhea, 26 per cent herpes and 26 per cent reporting syphilis as likely illnesses of sex workers in Mumbai. One third stated that it was difficult to know if a sex worker had one of these diseases, while the remainder felt they could tell by looking for sores on the penis (42%), discharge (32%), or observing if the sex worker had pain on urination. Nearly half (44%) of the clients reported having ever had an STD themselves with 21 per cent reporting having seen a doctor for an STD in the last six months.

Condom beliefs and general condom use

Clients were asked a shorter, slightly different set of questions about condom beliefs.

They reported that people use condoms to prevent infection (80%), for AIDS prevention (26%), and to prevent pregnancy (74%). The only common reason that people like condoms was for AIDS prevention and people do not like them because they cause an interruption (53%), they decrease sensation (37%), they are a lot of trouble to use (32%), and they have an unpleasant smell or taste (26%). More than half of the men knew the source of condoms in Mumbai and 84 per cent said they had never obtained one.

Clients were asked about their current condom use in general. Twenty-five per cent reported that they do not use condoms with any partners including MSWs, wives, lovers and casual partners. Another 35 per cent reported that they always use condoms with male lovers or intimate partners, 53 per cent always use condoms with casual male partners, and 56 per cent always use condoms with MSWs. Sexual practices may differ for different types of partners; but as our sample sized consisted of clients who were married they all said they did not use with their wives and the reason they said they had never used one till date and to start using one would prove that they are having extramarital sex.

Clients were also asked about their recent condom use. Twenty-five per cent used a condom at their last sexual encounter with a sex worker and 35 per cent at last sexual encounter with a partner who was not a sex worker. Nearly 85 per cent have asked a sex worker to use a condom and 44 per cent have been asked by a sex worker to use a condom. Forty-one per cent carry condoms with them.

Eighty-one per cent use a lubricant with condoms and 19 per cent use lubricated condoms.

General sexual history

Clients' age at first sexual relations with a man ranged from eight to 31 years with 21 per cent aged less than 14. Eighty-four per cent had had intercourse with a woman. Most had first paid for sex in their late 20s and early 30s. When asked what they enjoy when they are with sex workers, 25 per cent said that they liked to talk with them, 81 per cent said they enjoyed the sexual activities, and 44 per cent said that they enjoyed their companionship. Clients had paid sex workers a mean of 6.9 times in the last month. They had paid an average of 6.4 different sex workers. Most reported that they were usually with a prostitute for a short time (68%) but 50 per cent reported at least one all-night encounter. Some clients also reported being with a prostitute for several days (19%) or long term (6%). The average payment was about Rs.500 and 58 per cent of clients gave a non-monetary payment such as food /clothing, paid for mobile phone/bills or paid at times for rent/electricity bills.

Sexual experience in the last week

The clients reported paying a mean of 1.7 sex workers (range 1-4 partners) a mean 1.9 times (range 1-5 times) in the last week. Eighty per cent of their partners Male Sex workers and 17 per cent were other gay men. Table 5 summarizes the sexual practices reported in the last week by male clients. Masturbation was the most common practice, with oral intercourse the second most common. There was a smaller amount of anal intercourse reported both with and without condoms. Rimming (tongue to anus) was also reported with both sex workers and with other partners.

Female client reported vaginal sex and oral sex that included fellatio and cunnilingus

Table 5
Sexual acts experienced at least once in the last week by male clients of male sex worker (N=19)

Sexual act	With sex worker	With other partner
Masturbation (with either)	Every time	Every time

Sex workers Penis in client's mouth, no condom	Every time	Every time
Clients Penis in sex workers mouth, condom	Sometimes	Sometimes
Partner's penis in mouth, no condom	Every time	Every time
Partner's penis in mouth, condom	Every time	Every time
Sex workers Penis in client's anus, no condom	Sometimes	Sometimes
Sex workers Penis in client's anus, condom	Every time	Every time
Partner's penis in anus, no condom	Every time	Every time
Partner's penis in anus, condom	Sometimes	Sometimes
Tongue in partner's anus (with either)	Every time	Every time
Partner's tongue in anus (with either)	Every time	Every time
Fisting (with either)	Never	Never

It should be noted that MSWs report more recent experience with anal intercourse without condoms more than clients report. These differences may be due to the fact that they may perceive anal sex as demeaning to accept due to the stigma attached to it and underreporting by the clients could also have been a factor, although this is unlikely since they reported higher levels of anal sex with unpaid partners.

Alcohol and drug use
Heavy use of alcohol by clients was reported by both sex workers and by clients.

Ninety per cent of the sex workers report that they have clients who are drunk and 85 per cent of these workers use alcohol themselves before or during sexual encounters. Eighty-three per cent of the clients report that they become intoxicated. Forty-four per cent report giving alcohol or drugs to sex workers.

In contrast to this, use of other intravenous drugs was not reported. None of the sex workers reported intravenous drug use themselves and only five per cent of clients reported ever using intravenous drugs sometime. However, there past histories imply more risk of HIV infection: 48 per cent of clients have had sex with someone who was an intravenous drug user or probably was a non-intravenous drug user (24%).

Summary and discussion
Several limitations of this study must be kept in mind. The data comes from small; convenience samples and thus, generalizations to Mumbai and to other areas of India are limited. Only English-speaking clients were interviewed, although sex workers report their clients to include local middle-class persons as well quite some from lower middle class, and tourists from other parts of India and other countries. Because of difficulty of recruitment, both MSW and client data may undercount long-term relationships. Short-term visitors are probably underrepresented in the client sample and higher-priced sex workers may also be underrepresented. It should also be noted that the data are self-reports on sensitive topics that are not easily verified and most important this study was conducted over a period of two weeks

The data indicate that there is a very active community of male sex workers & masseurs and male/female clients in Mumbai that is at risk of transmission of AIDS infection. Male sex workers have limited knowledge of AIDS and STDs. Knowledge of transmission of these diseases is weak and they are unaware of asymptomatic transmission. Multiple sexual partners and frequent anal intercourse put the sex workers at risk. Condom use is low and sex workers possess ambivalent attitudes about their use; they frequently experience STDs and self-treatment with antibiotics is common as they report stigmatization by

health-care providers. These men are characterized by considerable mobility and many are sexually active on frequent travel and home visits to other parts of India- such as their area of domicile- Uttar Pradesh, Rajasthan, Bihar, Himachal Pradesh

In terms of the ARRM model, many workers were at stage one, the labeling stage. The sex workers had inaccurate information about AIDS and other STDS and proposed ineffective strategies such as choosing 'clean' partners for risk reduction. As discussed below, interventions with these men should begin with messages that focus on which behaviours lead to HIV and STD prevention to influence labeling of high-risk behaviours as problematic. As more sex workers progress to stages two and three of the ARRM model, the commitment and enactment stages, interventions should include skills development in condom negotiation and use. Interventions among sex workers could take advantage of social networks existing in the community. Education about these diseases and the development of skills to negotiate condom use and safer sexual practices could be organized through these networks.

The Male clients, in contrast, have considerable knowledge of AIDS and STDs.

However, multiple sexual partners, including sex workers, other gay man and their female spouses; ambivalent attitudes toward condom use, resulting in irregular use, put the clients and their sexual partners at risk of infection. Many though aware of sources of condoms in Mumbai do not buy or procure them and leave the onus on MSW & Masseurs and most of the time decline use of condoms.

High levels of alcohol use were reported before and during sexual encounters and may be a factor in increasing risky sexual behaviours. The clients have histories of STD infection and many report travel to different parts of the countries.

In terms of the ARRM model, the clients have in general moved beyond stage one, the labeling stage, into commitment and enactment stages. Obstacles to moving toward the enactment stages in this group may include negative beliefs about condoms as well as the idea of retaining condoms on person. An additional obstacle may be that many of them do not generally feel susceptible to HIV infection.

Health-care services that provide appropriate STD diagnosis and treatment without disapproval also need to be developed for workers in the area. Similarly, services for clients are also lacking. It should be noted that both groups have sufficient income to pay for services, so that once established, the services could become self-supporting. In addition, increasing availability of good quality condoms and water-soluble based lubricants for both sex workers and clients should enhance disease prevention.

These should be readily available at the sites where sex workers and clients meet, as well as in places of lodging for tourists and other places where sexual encounters take place.

Needs:

- ✓ To look at issues of Adolescent & Youth in sex work
- ✓ To look at issues of Sexual behaviour versus Sexual identity
- ✓ To look at Masculinity in terms of client negotiations per se high risk behaviour

- ✓ To look at Medico legal issues per se section 377 of IPC and ITPA section7, 7(i), 8.
- ✓ To look at after care and sustenance of positive sex workers

Conclusions:

- Strongly recommend the establishment of a local support service for men and boys selling sex
- Recognize diversity of individuals and subgroups
- Make firm links with local sexual health services
- Use outreach and networking to publicize project
- Provide information to local agencies to raise awareness of men/boys selling sex
- Undertake further research to inform practice

11) Cursory Sex mapping of Male Sex workers and Masseurs sites in Mumbai city

BACKGROUND &INTRODUCTION:

Over the years, sexual contact has remained the single most important risk factor for HIV transmission in India. We still do not have the exact ratio of the reported HIV infection that could have occurred through sex, with a hetero-to-homo sexual ratio collated with Substance abuse

What then are the contexts? For sexual behaviours, the contexts are the *geography* and the *dynamics* of high-risk sexual behaviours on a societal level. Experiences in countries like Thailand have alerted us of the phenomenal link between commercial sex and the homosexual HIV epidemic. Extensive commercial sex practice had subsequently been demonstrated to predispose to the spread of HIV in South East Asia. In India and specifically in Maharashtra and the financial capital of India – Mumbai the Mecca of migrants;

There has not been any systematic study on the distribution of Homosexual sex and Male commercial sex industry. The information gap would make it difficult to predict the possible trend of HIV spread in the future. On the other hand, human mobility is long known to be associated with spread of communicable diseases like STI from countries to countries. With the ever-closer inter-relationship between Mumbai and other states of India- there is the new question of whether HIV could spread across the districts through homosexual & non-and commercial male sex activities in both directions. Again, there is the vacuum of knowledge in relating cross-district traffic with homosexual sex activities.

We can conclude for now but would need more detailed study that casual and commercial sex and substance abuse taking behaviours are the two major groups of factors catalyzing the spread of HIV in the MSM community. The emphasis here is the risk to the population rather than an individual, as the consideration of the latter may be different. Once the HIV virus is introduced to a population, the rapidity of its dissemination would depend on the number of sex partners - a higher number of sex partners for an individual on a population scale means a higher overall chance of getting exposed to the virus, the practice of unprotected sex - a low condom usage rate in sexual activity implies a higher chance of exposure to the virus, the use of alcohol and other non intravenous illicit drugs - more people involving in the practice of non intravenous drug abuse, and/or a

higher rate of injection would predispose to a higher chance of contracting the virus.

The challenges to public health and behavioral scientists are to convert these seemingly basic and universally accepted principles into specific surrogates, which can be used routinely for monitoring population risk to HIV. In the epidemiological study of HIV, as for other communicable diseases, the concepts of incidence and prevalence are used. The questions frequently put to researchers were: what are the equivalents of incidence and prevalence in sex and non-intravenous drug-taking behaviours? Is there a common formula for their determination in each of the basic types of behaviours described?

Sexual contact is the major mode of HIV transmission; it is not known, however, how widespread the practice of high-risk sexual behaviours (unprotected anal and oral sex) and multiple sex partners {male and female partners}) is.

The portrayal of AIDS scenario is incomplete without addressing the risk patterns of the population. To date unprotected sex and substance abuse as alcohol and Marijuana (Ganja), Hashish (Gard) amongst the college and single living bachelors.

REPORT:

The sex mapping was undertaken by Samabhavana society in January 2004 frustrated by the fact that agencies do not believe the numbers and area of operations exist and most recently the unsuccessful attempt by Synovate to do so under the auspices of Avert where, in spite of offering full support they could not map a single site in city of Mumbai the cursory mapping of MSM high-risk sex behaviours was attempted, through the collection of information on ten sites out of a huge number provided by Synovate of 187 MSM mapped sites, the sites were reduced to the distance and more so due to lack of time and personnel and non existing budget , we could not conduct a comprehensive mapping as we wished.

These were performed through the conduction of a series of qualitative fact-finding studies using the following format a team of five voluntary outreach workers were sent out for a period of three weeks starting from 5th January to 26th January 2004 then the same information was collated and filled in an excel sheet and a mean time and day was determined along with number of persons at any given time

From the analysis, the main formats of MSW & Masseurs sex 'premises' were described – Beaches, Gardens/Parks, Toilets/Hotel lobbies, massage parlour, street walking and Internet centers. The area distribution of these premises was mapped, together with an assessment of the prevailing practice of unprotected sex. The picture was diverse and far from complete, though it managed to highlight the varied pattern of MSW & Masseur commercial sex in Mumbai City

Targeted Group: MSW & Masseurs *& It's various sub segments –Homosexual* Sex Workers, Bisexual Sex Workers and Heterosexual Sex Workers

SR. NO	*TOWN*	*AREA*	*LANDMARK*	*TYPE OF GROUP*	*PEAK TIME*		*LEAN DAY*		*NOS*	*CLIENTS*
					LEAN TIME	*PEAK TIME*	*LEAN DAY*	*PEAK DAY*		
1	Mumbai	Colaba	Gateway Promenade	Malishwalas & MSW	This was one of the sites is active in the evenings only			All days	*15-20*	*Visitors-National & Inter National*

										(male and Females) MSM,
2	Mumbai	Chow patty	Opp Wilson college, Marine Drive	Masseurs	This was one of the sites is active in the evenings only			All days	*150-200*	*Visitors-National & Inter National-males and Females, MSM,*
3	Mumbai	Bandra Station	Near platform no: 1	MSW	This was one of the sites that was round the clock active			All days	*15-20*	*MSM*
4	*Mumbai*	Andheri Station	Near Macdonalds & Outside platform no: 1	MSW	This was one of the sites that was round the clock active			All days		*MSM*
5	*Mumbai*	Juhu Beach	Near Gandhiji`s Statue	Masseurs	This was one of the sites is active in the evenings only			All days	*150-200*	*Visitors-National & Inter National (males and Females), MSM,*
6	*Mumbai*	Kurla Station	Outside platform No: 1	Malishwalas & MSW	This was one of the sites that was round the clock active but t times it is abandoned also			All days	*40-50*	*MSM and locals*
7	*Mumbai*	Film city		MSW (primarily) & Malishwalas	This was one of the sites were a lot of youth struggling to get a break do sex work as means of sustenance			All days	*400-500*	*Locals-Males and Females*
8	*Mumbai*	Madh Island Beach	Spread all over	Malishwalas	Weekends only			Weekends only	*100-150*	*Visitors_ female and Males*
9	*Mumbai*	Manori Beach/ Gorai beach	Spread all over	Malishwalas	Weekends only			Weekends only	*100-150*	*Visitors_ female and Males*
10	*Mumbai*	Kalbadevi,Masjid Bunder, Lakda bazaar	Spread all over	Malishwalas	4 A.M to 8 P.M	8.P.M to 4.A.M		All days	*400-500*	*Locals-Males and Females*

MAPPED AREA OF MUMBAI METRO WHERE WORK, CRUSING AND PICK UP TAKES PLACE

11) ABOUT US:

PROJECTS:

- Target Intervention Project From Maharashtra State AIDS Control Society (MSACS) in Poona City
- Cursory Sex Mapping of MSM sites in Poona city- MSACS project
- Baseline Study of MSM in Poona City – MSACS project
- Intervention with Male Sex Workers & Masseurs (Malishwalas) In Mumbai Metro – Non funded
- Website on Indian specific HIV/AIDS scenario in India: www.indiaids.org supported by UNAIDS and SHRC- DFID
- Social Marketing of condoms via condom cap and key chains in Mumbai, Maharashtra, Gujarat and Andhra Pradesh in collaboration with dktINDIA ltd – Non funded
- Marketing of ~adaa~ The Pleasure Pack – a comprehensive pack of condoms /lubes with flavoured condoms and lube – Non funded
- Saathi an MSM NGO based in Hyderabad – Andhra Pradesh has decided to merge with Samabhavana as we share common vision

ACTIVITIES:

Besides providing technical expertise to other Social Research agencies –IIPS, University of Connecticut, TISS, IMRB, ORG-MARG, Synovate and State Agencies

like Andhra Pradesh State AIDS Control Society – TRU, Avert and other state level MSM organizations in HIV/AIDS, Identity, Advocacy, Human rights and Law sector, awareness via Internet

- STI AND HIV/AIDS testing referrals with LTMG hospital – Mumbai and NARI - Poona
- Counseling on violence and abuse of Male sex workers
- Distribution of Female condom and Dental dams to bisexual and same sex preference women and MSW/Transgenders for penetrative anal and oral-anal sex in collaboration with Hindutan Latex Limited & Female Health Company- U.K
- Completed a KABP study on Male Sex Workers and Masseurs
- Completed a study on Sexual Behaviour of Male and Female Clients of MSW & Masseurs (Malishwalas)
- Completed a 70 Minute Documentary film on MSW & Masseurs (Malishwalas)
- Formation of Indian Male Sex Workers & Malishwalas Coalition (IMMC)
- Launch of Legal aid cell in Poona city with Support of Lawyers Collective
- Condom distribution/ safe sex workshops/STI referrals/ onsite counseling
- Job placement to HIV+ persons in collaboration with Salvation Army
- Development of Information education material

STATE/NATIONAL AND INTERNATIONAL ALLAINCES

- Networking Indian Network of NGO`s (I NN) on MSM issues.
- Networking with Kripa Foundation for Substance abuse issues
- Networking with Saaheli a Female Sex Workers Collective
- Networking with Human Rights Watch- New York-U.S.A on GLBT and MSW issues
- Networking with World Inter Pride organization on issues of Indian GLBTJ Identity
- Collaborating with Auckland pride and Sydney Mardi Gras on awareness of Indian sexual minorities issues
- Networked with Gay Games 2002 –Sydney-Australia for registration and delegation from India
- Networked with San Francisco pride on issues of Gay and lesbian Indians in U.S.A
- Networked with www.oneworld.org

EVENTS ORGANISED

- Human rights issues of persons with alternate sexuality and same sex Preference-co-organised conference with ICHRL on section 377 of IPC
- Co-organizing Human rights conference on 172nd LCI report with ICHRL, Forum for oppression against women, Stree sangam, Bailancho Saad, FACSE, IWID, Majlis, Olava, Saathi, Special Cell for Women and Children (TISS), Udaan+, Vacha and YWCA.
- Stall on World AIDS Day under the auspices of Avert as the Only Non funded NGO and 100 MSW & Masseurs took part in the Rally
- Valentine Day-2003- Same love awareness in 8 colleges of Mumbai with ICHRL, Stree Sangam and Humjinsi
- A workshop for *Bombay International High School*, Mumbai on issues of Abuse – sexual and drugs and Impact of internet for standard 9th & 10th children
- A workshop for Wilson College- Department of Mass Media on Sexuality

- A workshop for ILS- Law College-Poona- Department of Human Rights on Sexuality & Human Rights
- A workshop for Symbiosis Law College-Poona- Department of Human Rights on Sexuality, Male Sex Work & Human Rights
- Anal & Oral STI Awareness presided and Inaugrated by Dr.S.P Tripathi- Ex.D.G- I.C.M.R and Director- WHO
- Human Rights Awareness – Sexuality and HIV presided by Rtd.Justice Chapalgaonkar, Adv Anand Grover, Speakers Manisha Gupte and others

FUTURE PLANS:

On its cards the following projects:

- A center for persons with alternate sexuality and same sex preference alternate sexuality that will deal with identity, counseling and advocacy,
- Pride events
- Ezine on sexuality
- A day care shelter for HIV+ persons along with nutritional and psychological counseling,
- A vocational training center for those infected and affected that will provide a source for alternate income generation
- And last but not the least a Hospice in Maharashtra.

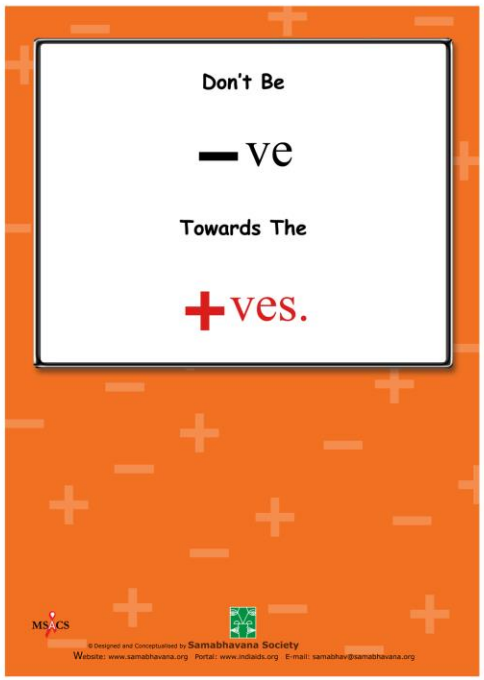
Courtesy: Pictorials-
Mr. Rudra K.M for the cover page and graphics special created for this manual

Acknowledgements:

Homophobia wheel of power: University of Texas
Human Rights & Law: Adv.Mihir Desai – I.C.H.R.L
Insights from our team of Volunteers & Indian Male Sex Workers & Malishwalas Coalition and above all for the continuous Support from the President Mr.D.K. Shenoy and the board of Samabhavana

12) INFORMATION EDUCATION AND COMMUNICATION (IEC) MATERIAL DEVELOPED BY US:

IEC-HIV/ AIDS



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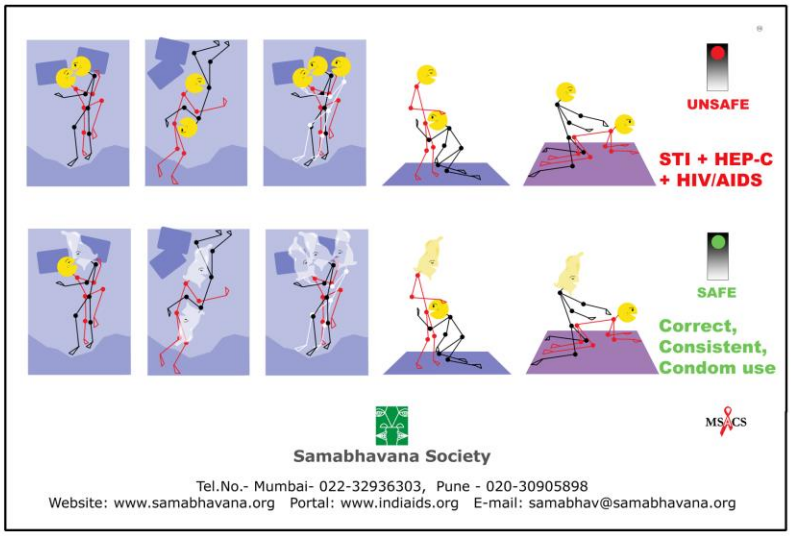
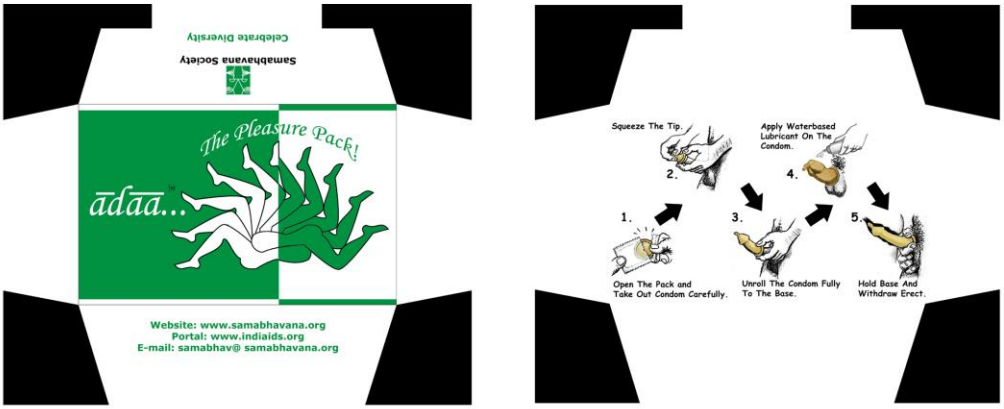
IEC- Safe Sex



IEC- Adaa Comprehensive pleasure pack: large
Contains 2 condoms+ lubricant+ tissue



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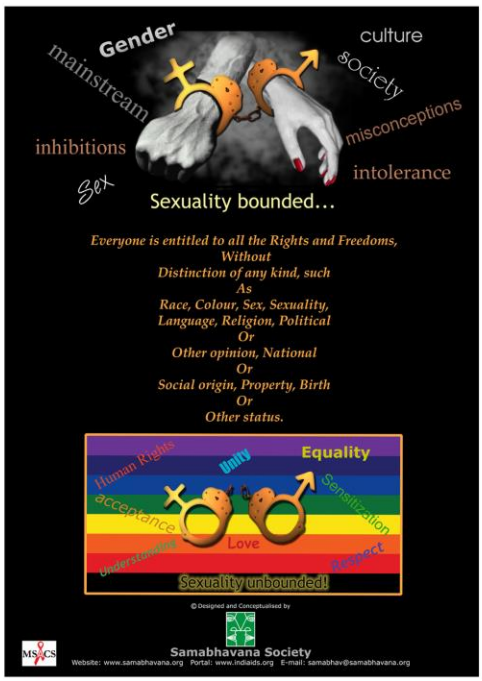
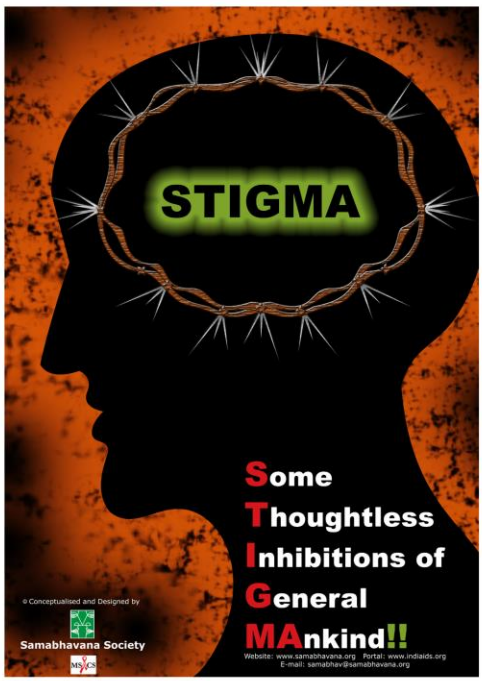
IEC- Human Rights.





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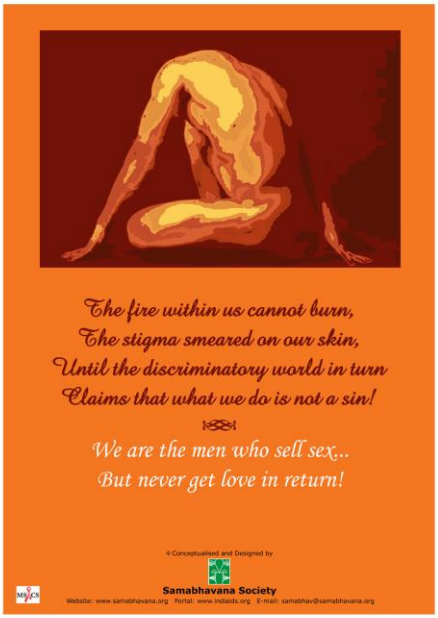
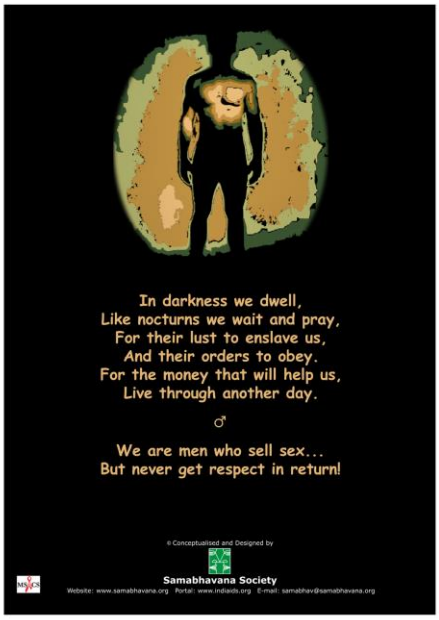
IEC- Male Sex Workers and Masseurs(Malishwalas)





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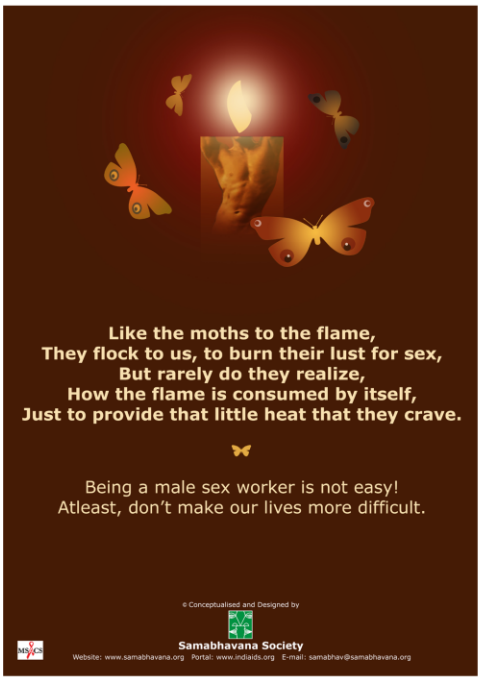
IEC- Male Sex Workers and Masseurs(Malishwalas)



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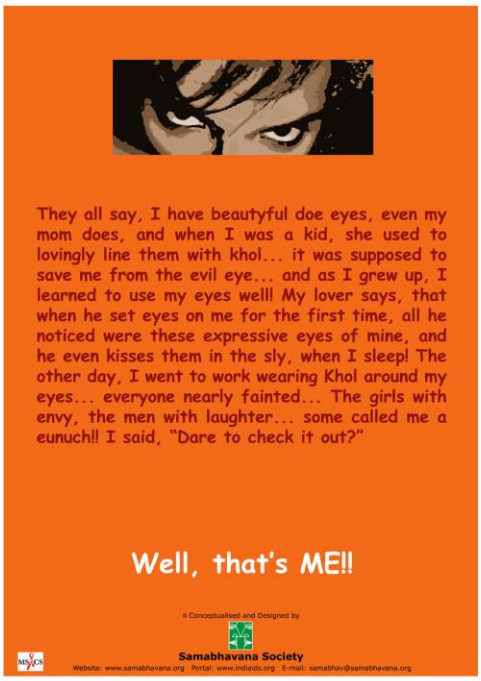
IEC- Sexuality (series)- Gay



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IEC- Sexuality (series)-

Bisexual-

Lesbian-

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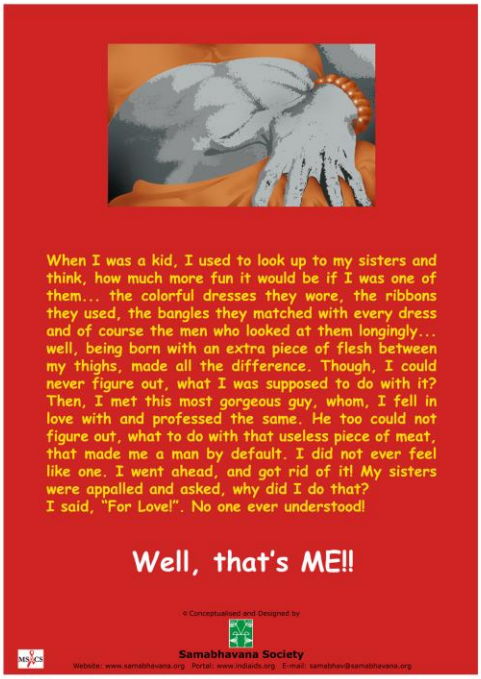
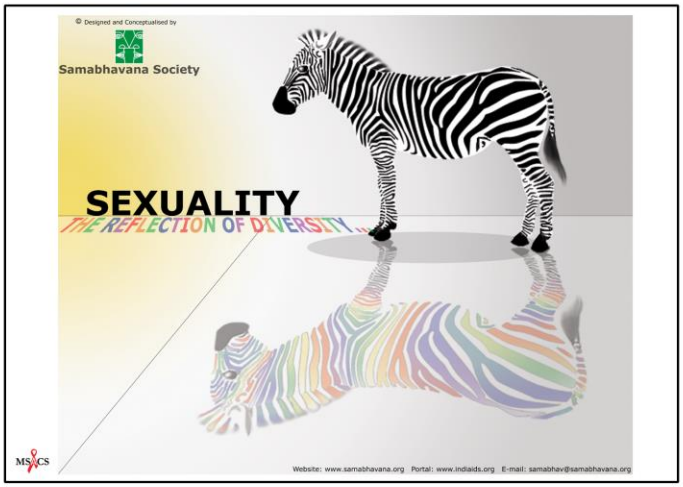
IEC- Sexuality (series)-

Transgender.



Independent Poster on sexuality.



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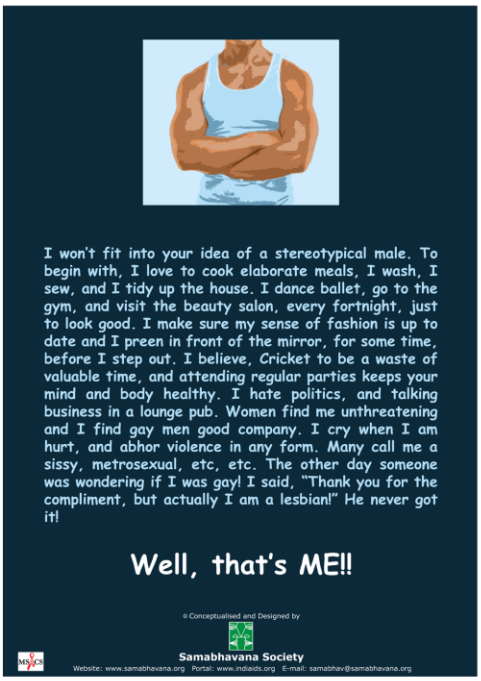
IEC- Sexuality (series)-

Heterosexual Male-



Heterosexual Female-

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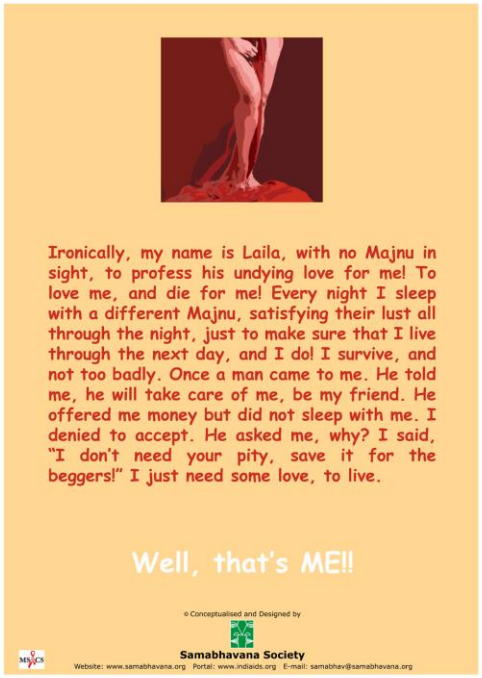
IEC- Sexuality (series)-

Female Sex worker-



Male Sex worker-